MDR Tracking Number: M5-03-0953-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that electrical stimulation, ultrasound therapy, therapeutic exercise, neuromuscular reed, joint mobilization, PT paraffin bath, PT unlisted modality, radiologic exam and MP office visits were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that electrical stimulation, ultrasound therapy, therapeutic exercise, neuromuscular reed, joint mobilization, PT paraffin bath, PT unlisted modality, radiologic exam and MP office visits fees were the only fees involved in the medical dispute to be resolved. As the treatment was not found to be medically necessary, reimbursement for dates of services from 5/9/02 to 7/31/02 are denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 7th day of March 2003.

Noel L. Beavers
Medical Dispute Resolution Officer
Medical Review Division

NLB/nlb

February 24, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-0953-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel. The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a female who sustained a work related injury on ___. The patient reported that while working as a claims analyst, she sustained a repetitive stress injury to both hands. The patient underwent an MRI that showed carpal tunnel syndrome on the right side. The patient was treated with carpal tunnel release and tunnel steroid injection. The patient was also treated with chiropractic care and physical therapy.

Requested Services

PT one area, electrical stimulation, ultrasound therapy, therapeutic exercise, neuromuscular reed, joint mobilization, PT paraffin bath, PT unlisted modality, radiologic exam and PM office OP visits from 5/9/02 through 7/31/02.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is upheld.

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that the patient sustained a work related injury to her right wrist on ___. The ___ chiropractor reviewer noted that the medical records provided contained minimal orthopedic and neurological testing. (Churchill Livingston; Orthopedic Testing: 1993.) The ___ chiropractor reviewer explained that there were no soft tissue findings and minimal chiropractic findings documented. The ___ chiropractor reviewer noted that the documentation provided failed to show the patient's change in pain from office visit to office visit. The ___ chiropractor reviewer noted that from office visit to office visit, the patient complained of decreased range of motion. However, the ___ chiropractor reviewer explained that the documentation provided failed to show what motion was decreased. The ___ chiropractor reviewer noted that from office visit to office visit, the patient complained of muscle spasms. However, the ___ chiropractor reviewer explained that the documentation provided failed to show what muscles were in spasm. The ___ chiropractor reviewer explained that the documents provided contained minimal clinical impressions. Therefore, the ___ chiropractor consultant concluded that the PT one area, electrical stimulation, ultrasound therapy, therapeutic exercise, neuromuscular reed, joint mobilization, PT paraffin bath, PT unlisted modality, radiologic exam and PM office OP visits from 5/9/02 through 7/31/02 were not medically necessary to treat this patient's condition.

Sincerely,

___