MDR Tracking Number: M5-03-1096-01

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 requestor submitted a medical dispute resolution request on 1/7/03 and was received in the Medical Dispute Resolution on 1/7/03. The disputed dates of service 12/4/01 through 1/3/02 are not within the one year jurisdiction in accordance with Rule 133.308(e)(1) and will be excluded from this Finding and Decision.

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 office visits with manipulations, DME, physical therapy and reports 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 office visits with manipulations, DME, physical therapy and report 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 service from 1/7/02 to 7/2/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 12th day of May 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

May 9, 2003

NOTICE OF INDEPENDENT REVIEW DECISION
Corrected Letter

RE: MDR Tracking #: M5-03-1096-01

___ 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 55 year-old male who sustained a work related injury on ___. The patient reported that while at work he was driving a forklift when the seat came loose throwing him off balance. This caused the patient to grab the bar on the forklift, swinging him around and causing him to twist his left wrist and arm. The patient was initially diagnosed with hand/wrist tenosynovitis, shoulder joint stiffness and elbow sprain/strain. The patient underwent an EMG on 11/14/01 and MRI in May of 2002. The patient underwent a carpal tunnel release and ganglion cyst excision on 8/21/02. The patient was referred to therapy post surgery.

Requested Services

Office visits/manipulations, DME, physical therapy, special reports on 1/7/02 through 7/2/02.

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 on ___. The ___ chiropractor reviewer also noted that the patient underwent surgery for his injury and was treated with physical therapy post surgery. The ___ chiropractor reviewer indicated that the treatment notes fail to support the need for continued treatment. The ___ chiropractor reviewer also explained that the treatment notes do not provide objective documentation to substantiate the need for continued care. Therefore, the ___ chiropractor consultant concluded that the office visits/manipulations, DME, physical therapy, special reports on 1/7/02 through 7/2/02 were not medically necessary to treat this patient's condition.

Sincerely,