

**THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

SOAH DOCKET NO. 453-03-3465.M5

MDR Tracking Number: M5-03-1231-01

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, 2003 and Commission Rule 133.305 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review 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 the office visits w/manipulations, physical therapy manipulations, myofascial release, therapeutic procedure, physical medicine treatment, ultrasound therapy, data analysis, special reports and 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 the office visits w/manipulations, physical therapy manipulations, myofascial release, therapeutic procedure, physical medicine treatment, ultrasound therapy, data analysis, special reports and office visits 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 1/21/02 through 6/28/02 are denied and the Division declines to issue an Order in this dispute.

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

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

April 18, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-1231-01

___ 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 45 year-old female who sustained a work related injury on ____. The patient reported that while at work she suffered a repetitive motion injury. The patient has worked as a ___ for 22 years. The patient reported that while performing her job, she does a lot of typing, reaching, bending of the shoulders and neck and talking on the phone. The patient reported that these repetitive motions have caused her pain in her shoulders, neck, and forearm areas. The patient has undergone carpal tunnel injections, physical therapy, and chiropractic manipulations and care. The diagnoses for this patient included bilateral carpal tunnel syndrome and myofascial pain of the bilateral upper trapezius, cervical paraspinals, thoracic paraspinals and left phomboids.

Requested Services

Office visits with manipulations, physical therapy manipulations, myofascial release, therapeutic procedure, physical medicine treatment, ultrasound therapy, data analysis, special reports and office visits 1/21/02 through 6/28/02.

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 indicated that this patient was sent to several doctors for evaluation and treatment. However, the ___ chiropractor reviewer explained that the treatment the patient received did not help her. The ___ chiropractor reviewer noted that the patient underwent surgery for her work related injury. The ___ chiropractor reviewer explained that after the surgery, it is appropriate to treat the patient with a few weeks of therapy. The ___ chiropractor reviewer indicated that the patient received extensive amount of conservative care. However, the ___ chiropractor reviewer explained that there was no improvement in this patient's condition. The ___ chiropractor reviewer also explained that because there was no improvement in this patient's condition with the extensive care given, the care should have stopped. Therefore, the ___ chiropractor consultant concluded that the office visits with manipulations, physical therapy manipulations, myofascial release, therapeutic procedure, physical medicine treatment, ultrasound therapy, data analysis, special reports and office visits from 1/21/02 through 6/28/02 were not medically necessary to treat this patient's condition.

Sincerely,