

MDR Tracking Number: M5-03-1270-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(q)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The office visits and physical therapy were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for office visits and physical therapy charges.

This Finding and Decision is hereby issued this 8th day of May 2003.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 1/24/02 through 4/23/02 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 8th day of May 2003

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/rl

NOTICE OF INDEPENDENT REVIEW DECISION

April 23, 2003

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
4000 South IH-35, MS 48
Austin, TX 78704-7491

RE: MDR Tracking Number # M5-03-1270-013
IRO Certificate #: IRO4326

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule § 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, ___ relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care.

___'s health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient sustained a work-related injury on ___ when she developed hand pain as well as right neck and shoulder pain as a result of repetitive work. The patient has been diagnosed with mild carpal tunnel syndrome on the right and diffuse myofascial pain syndrome with spasms of the bilateral upper trapezius. The patient was under the care of chiropractor and from 01/24/02 through 04/23/02, underwent office visits and physical therapy.

Requested Service(s)

Office visits and physical therapy from 01/24/02 through 04/23/02

Decision

It is determined that the office visits and physical therapy from 01/24/02 through 04/23/02 were medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The medical record documentation indicates that the patient received trigger point injections to the bilateral para-spinous, thromboids, and upper trapezius as well as the right elbow. Following each set of injections, the patient underwent post-injection therapy in order to decrease scar tissue, inflammation, and muscle contractions while improving muscle tone. Current literature states that post-trigger point injection therapy is required to relax the muscles, increase blood flow to the affected area, reduce muscle contractions and improve tone, strength, and flexibility. Therefore, the office visits and physical therapy from 01/24/02 through 04/23/02 were medically necessary.

Sincerely,