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

SOAH DOCKET NO. 453-04-1321.M5

MDR Tracking Number: M5-03-1320-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General 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. This dispute was received on 1-21-03.

The IRO reviewed chiropractic treatment rendered from 1-25-02 through 3-14-02 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

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 not the only issue** to be resolved.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On May 30, 2003, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The services in dispute were also denied based upon "R". A review of TWCC records revealed that a Benefit Review Conference was held, and the claimant was found to have sustained a compensable wrist injury. Since the IRO found that these services were not medically necessary, no reimbursement is recommended.

This Decision is hereby issued this 3rd day of November 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

April 14, 2003

Re: IRO Case # M5-03-1320-01

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IRO's, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic who is licensed by the State of Texas. He or she has signed a certification statement attesting 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 referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case. The determination of the ___ reviewer who reviewed this case, based on the medical records provided for review, is as follows:

History
The patient was injured on ___. She repetitively sews pockets on pants every day. She presented for treatment to her right wrist. She had surgery on 4/10/02 for release of right De Quevain's disease, after failure of chiropractic treatment. She had initially had a two-week trial of physical therapy with poor results from her employer's doctor prior to seeking treatment from the treating doctor whose services are in dispute.

Requested Service(s)
Office visits, myofascial release, ultrasound, electrical stimulation, hot or cold packs, neuromuscular stimulator 1/25/02-3/14/02

Decision
I agree with the carrier's decision to deny the requested treatment.

Rationale
The documentation presented for this review does not support the therapeutic effectiveness of the treatment that was provided for the patient's injury. The documentation of the patient's response to treatment is vague, but it evidently failed, as surgery had to be performed.
Treatment in the form of ultrasound, electrical muscle stimulation, myofascial release, heat/ice therapy and exercises were used, but the documentation presented does not demonstrate their effectiveness. Also, the relationship between neck pain and the patient's wrist injury was not established.
It appears from the treatment notes presented that every imaginable form of treatment was used for this patient, and it is possible that over utilization actually exacerbated the patient's symptoms. Treatment must be reasonable and effective in relieving symptoms or improving function, and the documentation presented failed to demonstrate this.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

Sincerely,

____