

MDR Tracking Number: M5-03-1668-01

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 (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 office visits, physical therapy sessions and injections 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 visit, physical therapy and injection 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 3/7/02 to 6/25/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 1st day of May 2003.

Noel L. Beavers
Medical Dispute Resolution Officer
Medical Review Division

NLB/nlb

April 23, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

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IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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 care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records

and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor specialized in Occupational Medicine. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

CLINICAL HISTORY

___ is a 60-year-old gentleman, a ___ who is right-hand dominant who sustained injury to his right elbow and shoulder region on ___ when lifting a tire to put in his truck. At that time, he felt a sudden pain to the elbow that radiated up to the shoulder. He then began with weakness in the entire right upper extremity, especially in the hand, and was also unable to lift heavy things because of pain around the elbow region. It appears that he was initially seen by ___ and ___. He was referred to ___ who recommended nerve conduction/EMG studies for his diagnoses of ulnar nerve neuritis and medial epicondylitis.

The electrodiagnostic studies were done by ___ on 11/7/00. For some reason, he again had a nerve conduction and DSEP studies of the left upper extremity on 12/18/00 by ___.

___ then saw ___, a neurosurgeon, who proceeded with surgery on 3/13/01. After surgery he was seen by ___, a pain management specialist.

___ attended therapy at ___. He also had two FCEs.

___ then underwent treatments which included electrical stimulation, myofascial release, electrical current therapy, therapeutic exercises and injections by ___, and appears to have been extended from 3/5/02 through 6/25/02, according to the medical records.

According to ___ note of 10/5/01, ___ had suffered injuries in the past and had undergone neck surgery in 1995. The neck surgery apparently had good results, and he had completely recovered with medications and physical therapy.

DISPUTED SERVICES

Under dispute is the medical necessity of office visits, physical therapy sessions and injections provided from 3/7/02 through 6/25/02.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

Of concern from reviewing the medical records that were provided for this report is ___ letter of Medical Necessity, dated 1/13/03. It shows that ___ injured his cervical spine and his right shoulder on his date of injury of ___. He states that while ___ was lifting a spare tire and placed it on the truck, he immediately felt severe neck pain and right arm pain. He presented with neck pain radiating to both shoulders and associated with numbness and a tingling sensation. He states that the right side of the neck pain was greater than the left side. He also states that ___ was diagnosed with severe myofascitis of the cervical paravertebral and trapezius muscles and he also suffered from multiple disc herniations and cervical radiculopathy.

However, reviewing the letter from ___ dated 10/27/00, ___ states that when ___ was lifting a tire to put it on the truck he felt a sudden pain to his elbow radiating to the shoulder. ___ makes no mention of any complaints regarding the cervical spine. The examination of the neck revealed a scar but a full range of motion and some right trapezius tenderness and spasms. The patient maintained a full range of motion across the shoulder with some pain at the extremes of internal rotation. ___ also states that ___ had a history of surgery by ___ to the right shoulder and that he also had cervical spine surgery in 1986 in ___.

___ underwent surgery by ___ on 3/13/01 and he appeared to continue with complaints postoperatively, for which he was sent to ___, pain management. ___ note of 1/30/02 shows that ___ is status post CESI on 1/15/02 and he reported a 50% pain relief for ten days with the procedure. However, the pain resurfaced. The pain was intermittent, dull and achy to the neck area and radiated to the shoulders and hands with slight numbness. However, on the physical examination ___ states only mild tenderness over the left cervical paraspinal region with cervical range of motion restricted upon right lateral bending due to radicular pains to the left upper extremities. Grip strength was adequate.

The FCE done on 4/22/02 showed that the reported job demand level was LIGHT. The testing showed that ___ qualified for the MEDIUM work category, though he was over-guarded and self-limiting in his performance throughout the FCE.

Because the reviewer found no documentation from ___ to justify the treatments given to ___ from 3/7/02 through 6/25/02, and because ___ report shows that the examination shows only mild tenderness over the cervical spine paraspinal region, the reviewer finds no documentation to support the medical necessity of the office visits, physical therapy sessions and injections from 3/7/02 through 6/25/02.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy

As an officer of ____, I certify that there is no known conflict between the reviewer, ____ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

____ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,