MDR Tracking Number: M5-03-1810-01

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 **or 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, required reports, supplies, physical therapy sessions 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 these fees were not the only fees involved in the medical dispute to be resolved. Carrier indicates payment issued for range of motion on 4-18-02 and 5-21-02, and muscle testing on 6-27-02. As the treatment was not found to be medically necessary, reimbursement for dates of service from 4-18-02 through 7-10-02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 10th day of June 2003.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

DZT/dzt

NOTICE OF INDEPENDENT REVIEW DECISION

June 4, 2003

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

MDR Tracking #: M5-03-1810-01
IRO Certificate #: IRO 4326

___ 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. ___ 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 was injured at work on ___ while working on an assembly line. She struck the dorsum of her right second and third metacarpal joints against a belt area and had acute onset of pain in her right wrist. She was under chiropractic care for eight months. The patient underwent surgical intervention on 03/26/02 for DeQuervain's release and a right tenosynovectomy.

Requested Service(s)

Range of motion testing, diathermy, physical medicine treatment, therapeutic procedure, office visits, myofascial release, joint mobilization, group therapy procedure, muscle testing, special reports, and supplies for date of service 04/18/02 and from 06/19/02 through 07/10/02

Decision

It is determined that the range of motion testing, diathermy, physical medicine treatment, therapeutic procedure, office visits, myofascial release, joint mobilization, group therapy procedure, muscle testing, special reports, and supplies for date of service 04/18/02 and from 06/19/02 through 07/10/02 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

After the patient was released for post surgical care and by the time the first functional capacity (FCE) was performed on 05/21/02, at least 17 sessions of post operative active and passive care had been completed. The medical record did not show that an FCE was done prior to the initiation of the post surgical care on or before 04/22/02. It is obvious that on 05/17/02 a significant regression of symptomatology had been observed from the previous FCE. It should be noted, however, that the previous FCE was pre-surgical. The care in question cannot be certified as to its medical necessity due to the lack of evidence of objective progress and therapeutic gain as per comparable objective studies.

Furthermore, there are no indications during the days in question or before where significant psychosocial issues are raised that could have impact on the patient's recovery. Therefore, group therapy procedures are not medically necessary as well. In addition, any testing, reports, or supplies during these dates of service, due to the failure to procure an initial FCE following surgery and due to the lack of documented evidence of therapeutic gain after surgery and up to the next re-examination period, are not medically necessary as well. Therefore, it is determined that the range of motion testing, diathermy, physical medicine treatment, therapeutic procedure, office visits, myofascial release, joint mobilization, group therapy procedure, muscle testing, special reports, and supplies for date of service 04/18/02 and from 06/19/02 through 07/10/02 were not medically necessary.

Sincerely,