MDR Tracking Number: M5-03-2415-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 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. The dispute was received on 5-27-03.

The Medical Review 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, joint mobilization, paraffin bath, electrical stimulation, manual traction, myofascial release, medical conference, MRI, unlisted neurological, NCV study, H&F reflex study, application of surface neurostimulator and initial observation care visit 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 Medical Review Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service from 5-30-02 through 10-18-02 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 7th day of October 2003.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

DZT/dzt

September 17, 2003

NOTICE OF INDEPENDENT REVIEW DECISION
Corrected Letter

RE: MDR Tracking #: M5-03-2415-01

___ 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 50 year-old female who sustained a work related injury on ___. The patient reported that while at work she began to experience pain in both wrist while lifting lead plates from batteries going down an assembly line. The diagnosis for this patient is bilateral carpal tunnel. The patient underwent a right wrist carpal tunnel release in August of 2000. The patient continued to complain of pain and began chiropractic treatment that included joint mobilization, electrical stimulation, manual traction and myofascial release. The patient also underwent an MRI of the right wrist on 7/6/02. Previously the patient has also been treated with physical therapy and oral pain medications.

Requested Services

Joint mobilization, paraffin, office visits, medical conference, MRI, electrical stimulation, unlisted neurological, NCV, H/F reflex study, application surface neuro-stimulator, manual traction, myofascial release, initial observation care-E&M visit from 5/30/02 through 10/18/02.

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 this case concerns a 50 year-old female who sustained a work related injury to both her wrist on ___. The ___ chiropractor reviewer also noted that the diagnosis for this patient is bilateral carpal tunnel syndrome. The ___ chiropractor reviewer further noted that the patient has been treated with physical therapy, oral pain medications, joint mobilization, electrical stimulation, manual traction, myofascial release and a right wrist carpal tunnel release in August of 2000. The ___ chiropractor reviewer explained that the patient received extensive treatment from 5/30/02 through 10/18/02. However, the ___ chiropractor reviewer also explained that the patient did not make significant progress despite the treatment rendered. Therefore, the ___ chiropractor consultant concluded that the joint mobilization, paraffin, office visits, medical conference, MRI, electrical stimulation, unlisted neurological, NCV, H/F reflex study, application surface neuro-stimulator, manual traction, myofascial release, initial observation care-E&M visit from 5/30/02 through 10/18/02 were not medically necessary to treat this patient's condition.

Sincerely,