MDR Tracking Number: M5-03-2478-01

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 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 adverse determination that joint mobilization, myofascial release, therapeutic procedure, office visits, and medical conference 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 joint mobilization, myofascial release, therapeutic procedure, office visits, and medical conference 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 6/3/02 through 6/17/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 8th day of August 2003.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

August 5, 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 Doctor of Chiropractic. 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

___ suffered injuries to her right wrist and elbow while using a pop rivet gun at work on___. She was previously being treated for a ___ work injury to her chest, abdomen and thoracic spine. An MRI of the right wrist was positive for tenosynovitis of the right flexor carpi radialis, moderate to severe osteoarthritis first carpometacarpal articulation. EMG and nerve conduction study results were bilateral motor and sensory carpal tunnel syndrome, bilateral motor and sensory ulnar neuropathy, especially across the elbows. ___, an orthopedic surgeon, recommended six weeks of physical/occupational therapy. (He states in his 5/10/02 report that the patient did not have physical/occupational therapy.) ___, in his 6/20/02 report, also recommended continuing physical therapy. In the requestor's report dated 5/29/03 it is stated that the patient had already had eight weeks of a daily physical therapy program and not enough progress had occurred to return her to work, so she was referred to an orthopedic surgeon and more diagnostic studies were ordered. The patient had a functional capacity test on 7/10/02 and it was found that she still could not return to work.

DISPUTED SERVICES

Under dispute is the medical necessity of joint mobilization, myofascial release, therapeutic procedure, office visits and medical conference provided form 6/3/02 through 6/17/02.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

This patient had eight weeks of daily physical therapy care prior to the dates in question. This would be a reasonable time to see if therapy was producing positive results. The medical records provided indicate that the therapy was not producing positive results. All services provided between the dates of service 6/3/02 through 6/17/02 are deemed by the reviewer to not be medically necessary.

___ 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,