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

SOAH DOCKET NO. 453-04-0781.M5

MDR Tracking Number: M5-03-2483-01

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 6-5-03.

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 electrical stimulation, office visits w/manipulations, ultrasound, physical medicine treatment, myofascial release, neuromuscular re-education, supplies, and special reports were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee. The requestor submitted a letter of withdrawal for date of service 2-8-03 which had no EOB.

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 6-10-02 through 2-19-03 is denied and the Medical Review Division declines to issue an Order in this dispute.

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

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division
DZT/dzt

August 1, 2003

IRO Certificate# 5259
MDR Tracking Number: M5-03-2483-01

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___ or by the application of medical screening criteria and protocols formally established by practicing physicians. All available

clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY
___ was injured due to repetitive strain to both wrists on the job. The DOI is ___. She initiated care with ___on 2/13/02. She was also evaluated by a neurologist, ___, on 4/23/02 and ___, an orthopedist MD on 6/21/02. All three doctors agreed the diagnosis was bilateral carpal tunnel syndrome. An MRI of both wrists was performed on 5/10/02 with positive findings, including tearing of the fibrocartilige. ___ subsequently received surgery to both wrists.

REQUESTED SERVICE (S)
Chiropractic services rendered from 6/10/02 through 2/19/03.

DECISION
Uphold denial.

RATIONALE/BASIS FOR DECISION
Many treatment standards for chiropractic care in an uncomplicated case have established that a 2 week trial of initial care, of up to 5 visits a week, is reasonable and necessary. If this trial fails to give a reasonable amount of recovery, an additional two-week trial using an alternate treatment method warranted for a 4-week trial of care. If at the end of that 4-week trial no significant progress has been made, treatment has failed and referral to a different type of provider is warranted.

___ peer review finding was that treatment had failed, and further treatment beyond 6/10/02 was not justified. In addition, continued passive care into the chronic phase of treatment is contraindicated. Movement into active care is vital in most cases.

Additionally, ___appropriately referred ___for a second opinion with ___. He reported back to ___on 4/23/02 that ___, to sum it up, told him her symptoms were worsening, not improving. There is no evidence in ___ treatment records that the patient showed any signs of progressive recovery.

Finally, an MRI in mid May of 2002 revealed tearing of the fibrocartilige, and therefore the need for evaluation by an orthopedic surgeon. ___ refers to a symptom flare in July 2002, but there is no record of this in the file.

Therefore, despite ___ efforts, conservative passive care failed and further treatment was of no benefit.

The opinions rendered in this case are the opinions of the evaluator. This evaluation has been conducted on the basis of the medical examination and documentation as provided, with the assumption that the material is true and correct. If more information becomes available at a later date, an additional service/report/reconsideration may be requested.

Such information may or may not change the opinions rendered in this evaluation. This opinion is based on a clinical assessment, examination and documentation. This opinion does not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.

Medicine is both an art and a science, and although the patient may appear to be fit to participate in various types of activities, there is no guarantee that the individual will not be re-injured, or suffer additional injury as result of participating in certain types of activities.