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

SOAH DOCKET NO. 453-04-0846.M5

MDR Tracking Number: M5-03-2715-01

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 6-25-03.

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 w/manipulations, myofascial release, ultrasound, joint mobilization, neuromuscular reeducation, therapeutic activities, and physical medicine treatment 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 6-26-02 to 10-28-02 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 23rd day of September 2003.

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

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

September 19, 2003

Re: IRO Case # M5-03-2715-01

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic who is licensed by the State of Texas, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting 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 referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

History
The patient injured her right upper extremity, neck and shoulder while using a keyboard and mouse on ___. On 12/13/01 she presented for chiropractic treatment. She was placed at MMI on 9/4/02.

Requested Service(s)
Office visits with manipulations, neuromuscular reeducation, kinetic activities, myofascial release, joint mobilization, ultrasound therapy, physical medicine treatment, office visits, 6/26/02-10/28/02.

Decision
I agree with the carrier's decision to deny the requested treatment.

Rationale
The patient received some ten months of extensive chiropractic treatment for a case of carpal tunnel syndrome and ulnar nerve entrapment, that should have responded well

within eight to ten weeks of treatment. Yet on 2/15/02, the patient had a pain scale of 5/10.
In the designated doctor report of 5/22/02, it was noted that the patient had a sharp, burning, tingling pain that starts in the right wrist and radiates into the hand and up the arm and into the right shoulder, and that it occurred between ¾ of the time and all the time, and causes serious diminution in her capacity to carry out daily activities. These symptoms persisted after five months of treatment. The patient still had restricted cervical spine, right shoulder and wrist ranges of motion. There was weakness in the wrist extensors and hypoesthesia C6-T1, Phalen's and Tinel's signs were positive, as was maximum cervical compression. There was moderate to severe spasm and pain to palpation of the cervical spine, upper thoracic spine, right shoulder, elbow and wrist. Treatment was not effective in relieving symptoms and improving function, and it was not reasonable to continue it for such an extended time.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

Sincerely,