

MDR Tracking Number: M5-03-3069-01

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 7-25-03.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. The requestor withdrew CPT code 97112 for dates of service 11-19-02 and 11-21-02 and CPT codes 99213, 97110m 97112, 97250 and 97265 on 11-27-02. The office visits; therapeutic procedures, myofascial release, and joint mobilization were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

The above Findings and Decision are hereby issued this 24th day of November 2003.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 10-4-02 through 11-26-02 and 12-2-02 through 12-20-02 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 24th day of November 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M5-03-3069-01

September 3, 2003

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 Texas Medical Foundation, 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

___ is a ___. On ___, after an arduous day working with heavy copper cables, he felt pain and numbness in his right hand. His job description requires him to use his hands for repetitive tasks. He has been diagnosed with right carpal tunnel syndrome and right ulnar neuropathy across the elbow.

REQUESTED SERVICE(S)

Office visits, therapeutic procedures, myofascial release, joint mobilization for dates of service 10/4/02 through 11/26/02 and 12/2/02 through 12/20/02.

DECISION

Reverse prior decision. Approve services.

RATIONALE/BASIS FOR DECISION

The procedures used and the consistency in treatment the first four weeks are within normal standards of care for this type of injury. This patient was taken off work, and in order to try to return him to work, consistent treatment was required. As such, the treatment protocol recommends reducing treatment to 3x per week at the fourth week. Referrals and diagnostic procedures in this case were performed in an orderly and timely fashion. ___ report states myofascial release and massage are not acceptable because it was not included in the original diagnosis. These two procedures are of paramount importance in carpal tunnel recovery and not performing them is not rendering full care. Trigger points and adhesions are as much a part of carpal tunnel as carpal pain. As far as the patient performing home therapy as recommended by

____, a Saunders carpal decompression unit would need to be purchased for the patient. Also included in the records is documentation dated 1/28/03 in which ____ from the ____ field office rendered a decision that stated the claimant sustained a compensable, repetitive trauma injury on _____. Texas Labor Code states that an injured employee is entitled to reasonable medical care that alleviates or improves his symptoms. According to the reports sent, there were improvements in the patient's range of motion with the care rendered.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.