

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

**SOAH DOCKET NO. 453-04-1161.M5**

MDR Tracking Number: M5-03-3190-01

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 8-7-03.

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 the only issue** to be resolved. The therapeutic procedure, physical medicine treatment, office visits, myofascial release, office visits w/manipulation, and office visits from 8-12-02 through 12-3-02 were found to be medically necessary. The ultrasound and electrodes from 8-12-02 through 12-3-02 were not found to be medically necessary. The respondent raised no other issues for denying reimbursement for the above listed services.

The above Findings and Decision are hereby issued this 9<sup>th</sup> day of October 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 8-12-02 through 12-3-02 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 9th day of October 2003.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

September 27, 2003

### NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M5-03-3190-01**

\_\_\_ 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 reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. 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 26 year-old female who sustained a work related injury on \_\_\_. The patient reported that while at work she began to experience numbness in her fingertips and pain in both upper extremities to both shoulders and neck. The patient underwent an EMG/NCV and X-Rays of the elbows, wrists and cervical spine. The diagnosis for this patient is mild carpal tunnel syndrome bilaterally. The patient was treated with therapy that included electrical stimulation, heat, ultrasound and soft tissue mobilization. The patient has also been treated with trigger point injections and chiropractic manipulations. On 12/6/02 the patient underwent right carpal tunnel release surgery. After surgery the patient was treated with postoperative rehabilitation.

#### Requested Services

Therapeutic procedure, ultrasound, physical medicine treatment, office visits, myofascial release, electrodes, office visits with/MP and office visits from 8/12/02 through 12/3/02.

### Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is partially overturned.

### Rationale/Basis for Decision

The \_\_\_ chiropractor reviewer noted that this case concerns a 26 year-old female who sustained a work related injury to both shoulders and upper extremities and neck on \_\_\_\_. The \_\_\_ chiropractor reviewer also noted that the diagnoses for this patient have included mild carpal tunnel syndrome bilaterally. The \_\_\_ chiropractor reviewer further noted that the treatment for this patient's condition has included electrical stimulation, heat, ultrasound and soft tissue mobilization, trigger point injections and chiropractic manipulations. The \_\_\_ chiropractor reviewer indicated that post injection therapy is medically necessary as an adjunct treatment to aid in decreasing symptoms that the patient may have. (Dr. G. Ko M.D.; Muscle Pain: Trigger Points Diagnoses and Management, 2001). The \_\_\_ chiropractor reviewer explained that these treatments would include EMS, massage/myofascial release, therapeutic exercises and heat. However, the \_\_\_ chiropractor reviewer also explained that there is no literature that shows the benefits of ultrasound in post injection therapy. The \_\_\_ chiropractor reviewer indicated that the office visits between 8/12/02 and 12/3/02 were medically necessary for re-evaluation of the patient to track progress in therapy. The \_\_\_ physician reviewer explained that there is no documentation as to why additional electrode pads were needed for this patient. The \_\_\_ physician reviewer also explained that the manipulations performed on this patient during the time in question were medically necessary to treat the cervical region for subluxations. Therefore, the \_\_\_ chiropractor consultant concluded that the therapeutic procedure, physical medicine treatment, office visits, myofascial release, office visits w/MP and office visits from 8/12/02 through 12/3/02 were medically necessary to treat this patient's condition. However, the \_\_\_ chiropractor consultant concluded that the electrodes and ultrasound from 8/12/02 through 12/3/02 were not medically necessary to treat this patient's condition.

Sincerely,