MDR Tracking Number: M5-03-3363-01

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 (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 August 25, 2003.

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 determination that the office visits, myofascial release, therapeutic exercises, electrical stimulation and therapeutic activities 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 fees were the only fees involved in the medical dispute to be resolved. As the office visits, myofascial release, therapeutic exercises, electrical stimulation and therapeutic activities were not found to be medically necessary, reimbursement for dates of service from 9/3/02 through 10/11/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 19th day of November 2003.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division
MQO/mqo

November 17, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

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___ 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 reviewer is on the TWCC Approved Doctor List (ADL). 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

This patient was injured on his left wrist on his job and was initially seen by the company's doctor, who prescribed PT and medication. After about 3 weeks, the patient began treatment with ___ and was diagnosed with Carpal Tunnel Syndrome. This was confirmed by electrodiagnostic testing, as interpreted by ___. Initial treatment was successful and was documented to reduce the pain significantly. However, the improvement apparently leveled off. Surgery was suggested, but denied by the carrier. Records do indicate that MRI was performed on April 12, 2002 and indicated a possible avascular necrosis of the carpal lunate, along with a healing non-displaced fracture and generalized effusion. Records do not seem to confirm the presence of such a pathology. MMI was assessed by the treating doctor on September 23, 2002 and it was found that the patient had a 9% whole person impairment. A peer review was performed by ___which indicated that further care was unnecessary in this case. The review was performed on July 23, 2002.

DISPUTED SERVICES

The carrier has denied the medical necessity of office visits, myofascial release, therapeutic procedures, electrical stimulation and therapeutic activities from September 3, 2002 through October 11, 2002.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

Extensive care was rendered on this case, yet the patient did level off in the results of his care. The documentation in this file indicates that the patient was unlikely to improve with the care rendered and that the care could probably not be considered palliative in nature. With the very large amount of treatment combined with the lack of results from ongoing care, it is found that the treatment rendered was not necessary to treat the patient's condition.

___ 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,