

MDR Tracking Number: M5-02-2554-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 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 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(q)(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 disputed office visits, therapeutic procedures, modalities and physical performance tests were found to be medically necessary. The respondent raised no other reasons for denying reimbursement.

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 date of service 11/13/01 through 11/27/01.

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 19th day of March 2003.

Noel L. Beavers
Medical Dispute Resolution Officer
Medical Review Division

NLB/nlb

March 13, 2003

Rosalinda Lopez
Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5.02.2554.01
IRO Certificate No.: IRO 5055

Dear Ms. Lopez:

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic medicine.

Clinical History:

This 53-year-old female was in a work-related accident on ___, injuring her left wrist. Initial exam showed range of motion deficits. MRI of the left wrist on 12/17/01 showed non-specific signs of transverse carpal tunnel inflammation. Eight sessions of therapeutic procedures were applied from 11/13/01 through 11/27/01.

Disputed Services:

Therapeutic procedures, modalities, physical performance testing from 11/13/01 thru 11/27/01.

Decision:

The reviewer disagrees with the determination of the insurance carrier. The reviewer is of the opinion that the procedures and testing in question were medically necessary in this case.

Rationale for Decision:

The mechanism of injury shows probable deep contusion due to blunt compression caused by the patient's left hand being pinned. It was an appropriate clinical decision to begin a trial of physical therapy measures on this patient.

The aforementioned information has been taken from the following guidelines of clinical practice:

Texas Worker's Compensation Commission Upper Extremity Treatment Guidelines.

Overview of Implementation of Outcome Assessment Case Management in Clinical Practice. Washington State Chiropractic Association; 2001, 54 p.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,