MDR Tracking Number: M5-02-2914-01

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, the total amount recommended for reimbursement does not represent a majority of the medical fees of the disputed healthcare and therefore, the **requestor did not prevail** in the IRO decision. Consequently, the requestor is not owed a refund of the paid IRO fee.

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 office visits and therapies (including electrical stimulation, joint mobilization, myofascial release) were found to be medically necessary. The surface neuro-stimulation procedures were not found to medically necessary. The respondent raised no other reasons for denying reimbursement for these office visits and therapies charges.

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 8/17/02 through 3/6/02 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 10th day of January 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/crl

November 5, 2002

Re: Medical Dispute Resolution
MDR #: M5.02.2914.01
IRO Certificate No.: IRO 5055

Dear ___

___ 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 40-year-old female injured her right wrist while on her job on ___. MR imagings were done on 04/22/01. The patient received carpal tunnel surgery on the right wrist on 02/05/02.

Disputed Services:
Surface neuro-stimulation from 08/17/01 through 02/08/02, and office visits from 02/08/02 through 03/06/02.

Decision:
The reviewer partially agrees with the determination of the insurance carrier as follows:

- the surface neuro-stimulation procedures (Code 64550) administered during the period 08/17/01 through 02/08/02 **were not** medically necessary in this case.

- the office visits (Codes 99215 & 99213) during the period 02/08/02 through 03/06/02, the manual electrical stimulation (Code 97032) administered during the period 02/11/02 through 03/06/02, the joint mobilization procedures (Code 97265) performed during the period 02/11/02 through 03/06/02, and the myofascial release procedures (Code 97250) performed during the period 02/13/02 through 02/27/02 **were** medically necessary in this case.

Rationale for Decision:
The patient was in appropriate post-operative therapy during the period 02/08/02 through 03/06/02. It is appropriate to begin the post-surgical rehabilitation process as soon as the patient can tolerate the activity.

The use of surface neuro-stimulation was not appropriate in the treatment of this patient. The device operates with the premise to influence the perception/location of pain. The premise behind the use may be sound, but clinical, peer-reviewed, and published information is lacking.

Sources utilized:

- literature from The American Chiropractic Rehabiliation Board.
- "Clinical Practice Guidelines for Chronic Non-Maligant Pain Syndromes, II: An Evidence-Based Approach," published in the *Journal of Back Musculoskeletal Rehabilitation*, in 1999.

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,