

MDR Tracking Number: M5-02-3071-01

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 IRO determined the office visits, myofascial release, supplies/materials, iontophoresis, kinetic activities, therapeutic procedure, ultrasound therapy, electrical stimulation and application of a modality from 1/24/02 through 3/11/02 not medically necessary. The Medical Review Division has reviewed the IRO decision and determined that **the respondent prevailed** on the issues of medical necessity. Therefore in accordance with §133.308(q)(9), the Commission hereby **Declines to Order** the respondent to reimburse the **requestor** for the paid IRO fee.

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 services were found to **not** be medically necessary. The respondent raised no other reasons for denying reimbursement for these services.

This Decision is applicable to dates of service 1/24/02 through 3/11/02 in this dispute.

This Decision is hereby issued this 20th day of November 2002.

Noel L. Beavers  
Medical Dispute Resolution Officer  
Medical Review Division

NLB/nlb

**IRO Certificate #4599**

### **NOTICE OF INDEPENDENT REVIEW DECISION**

November 11, 2002

**Re: IRO Case # M5-02-3071**

Texas Worker's Compensation Commission:

\_\_\_ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation

Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IRO's, TWCC assigned this case to \_\_\_ for an independent review. \_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, \_\_\_ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Eligible in Orthopedic Surgery and a Fellowship trained Hand Surgeon. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to \_\_\_ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The \_\_\_ reviewer who reviewed this case has determined that, based on the medical records provided, the requested treatment was not medically necessary. Therefore, \_\_\_ agrees with the adverse determination regarding this case. The reviewer's decision and the specific reasons for it, is as follows:

#### History

The patient is a 34-year-old female with a long history of bilateral wrist pain. She was diagnosed with carpal tunnel syndrome and sent for therapy for three months with no response. She eventually saw a hand specialist who diagnosed with mid carpal instability.

#### Requested Service(s)

Office visits, myofascial release, supplies/materials, iontophoresis, kinetic activities, therapeutic procedure, ultrasound therapy, electrical stimulation, and application of a modality.

#### Decision

I agree with the carrier's decision to deny the requested services.

#### Rationale

Physical therapy is not an accepted treatment modality for carpal tunnel syndrome, or even mid carpal instability.

It is doubtful that the carpal tunnel is the generator of the patient's pain, but rather it is probably from the instability.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

### **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. A request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) 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 (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P O Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

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

Sincerely,