

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING
IS THE RELATED SOAH DECISION NUMBER: 453-03-3115.M5

MDR Tracking Number: M5-02-3261-01

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.

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 chiropractic treatment/services (evaluations, radiographs, office assessments and therapeutic exercises) from 8/20/01 through 11/30/01 were found to be medically necessary. Myofascial release, joint mobilization and manual traction were not medically necessary from 9/21/01 through 11/30/01. The respondent raised no other reasons for denying reimbursement for the chiropractic treatment/services charges.

This Finding and Decision is hereby issued this 26th day of March 2003.

Carol R. Lawrence
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 8/20/01 through 11/30/01 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 26th day of March 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

DRM/crl

NOTICE OF INDEPENDENT REVIEW DECISION

December 17, 2002
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
4000 South IH-35, MS 48
Austin, TX 78704-7491

RE: MDR Tracking #: M5-02-3261-01
IRO Certificate #: 4326

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced 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 rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care.

___ health care professional has signed a certification statement stating 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 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 this case.

Clinical History

This 34 year old female sustained a work related injury on ___ when a heavy roll of fabric fell on her right wrist. An examination revealed reduced and tender right wrist ranges of motion and hyperesthesia at the hand and wrist on the right. The neurological examination revealed normal reflexes and decreased sensation to touch in the C6, C7, and C8 dermatomes. X-rays of the wrist were unremarkable. The patient was diagnosed with injury to the elbow, forearm and wrist; and was also diagnosed with carpal tunnel syndrome. An MRI of the right wrist performed on 08/28/01 revealed a 5X10mm ganglion cyst. The patient underwent surgery for the ganglion cyst on 10/04/01. The patient was under the care of a chiropractor with a regimen consisting of myofascial release, joint mobilization, manual traction, and three units of therapeutic exercises.

Requested Service(s)

Chiropractic services provided from 08/20/01 through 11/30/01.

Decision

The initial evaluation and radiographs taken by the chiropractor were medically necessary for the treatment of the patient's condition. Office assessments and therapeutic exercises were medically necessary for the treatment of the patient's condition from 08/20/01 through 11/30/01. Myofascial release, joint mobilization, and manual traction were medically necessary from 08/20/01 through 09/20/01. Myofascial release, joint mobilization and manual traction were not medically necessary from 09/21/01 through 11/30/01.

Rationale/Basis for Decision

There was disagreement between the varied treating physicians as to the existence of carpal tunnel syndrome in the patient's wrist. The initial phase of active and passive chiropractic treatments for the first month (08/20/01 through 09/20/01) was medically necessary. However, due to the lack of benefit from the care rendered, the manual treatments after 09/20/01 were not medically necessary. Haldeman et al indicated that an adequate trial of care is defined as a course of two weeks each of different types of manual procedures (4 weeks total), after which, in the absence of documented improvement, manual procedures are no longer indicated, "Haldeman, S., Chapman-Smith, D., and Petersen, D. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen, Gaithersburg, Maryland, 1993. The patient has had a protracted course of care in excess of the parameters delineated by the above-mentioned document and has not demonstrated a favorable response to treatment. Therefore, manual treatments after 09/20/01 were not indicated or medically necessary.

The use of therapeutic exercises from 08/20/01 through 11/30/01 was medically necessary. The patient had a course of pre-surgical active care and then underwent surgery for the ganglion cyst on 10/15/01. Treatments resumed on 10/22/01 and the patient was treated until 11/20/01. The course of post-surgical active care was appropriate, reasonable, and medically necessary. Therefore, the initial evaluation and radiographs taken by the chiropractor were medically necessary for the treatment of the patient's condition. Office assessments and therapeutic exercises were medically necessary for the treatment of the patient's condition from 08/20/01 through 11/30/01. Myofascial release, joint mobilization, and manual traction were medically necessary from 08/20/01 through 09/20/01. Myofascial release, joint mobilization and manual traction were not medically necessary from 09/21/01 through 11/30/01.

Sincerely,