

MDR Tracking Number: M5-04-0253-01

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 September 22, 2003.

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(r)(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 office visits, myofascial release, ultrasound, electrical stimulation were found to be medically necessary. The respondent raised no other reasons for denying reimbursement of the office visits, myofascial release, ultrasound, and electrical stimulation 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 9/23/02 through 11/21/02 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 21st day of November 2003.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

November 20, 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

The history of this case involves a patient who was a long-term employee of ___ in ___ with ongoing pain in her left hand. The pain has been caused by repetitive trauma as a part of her job and she has reported numbness in the 3rd, 4th and 5th digits of the left hand. She changed doctors in 2002 to ___, who initiated a 2 month program of manipulation and active rehabilitation with some passive care. The patient continued to work at her job during her injury time and ___ encouraged conservative care to accommodate the patient's desired employment goals. He had diagnosed her with early carpal tunnel syndrome. Peer review by ___ indicated that no further care was reasonable or necessary at this stage.

DISPUTED SERVICES

The carrier has denied the medical necessity office visits, myofascial release, ultrasound, electrical stimulation, TWCC reports and therapeutic procedures.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The patient involved in this case was treated appropriately by the treating doctor. The care rendered was appropriate to the case, as indicated by the records presented. This patient has had multiple surgical procedures to her hands and has a predisposition toward injuries to this area of her body. The care rendered certainly met the goals of pain management as well as the rehabilitation of the patient's upper extremity. The reviewer finds that due to the documentation presented, the care would be considered reasonable and necessary.

___ 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,