

MDR Tracking Number: M5-04-0441-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 10-10-03.

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 \$650.00** 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, therapeutic procedures, myofascial release, joint mobilization, neuromuscular re-education, electrical stimulation, muscle testing, range of motion measurements, supplies, iontophoresis and noninvasive ear/pulse oximetry were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

This Findings and Decision is hereby issued this 21st day of April 2004.

Debra L. Hewitt
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 03-24-03 through 04-16-03 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 April 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dlh

April 20,2004

**NOTICE OF INDEPENDENT REVIEW DECISION
Corrected Letter B**

RE: MDR Tracking #: M5-04-0441-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in physical medicine and rehabilitation. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a female who sustained a work related injury on ___. The patient underwent carpal tunnel release. The patient was then referred to post carpal tunnel release therapy and rehabilitation from 11/22/02 through 1/13/03. A left wrist X-Ray dated 1/15/03 showed an irregular jog in the radial aspect of the distal radial metaphyseal cortex. The patient then underwent an MRI of the left wrist dated 1/29/03. The patient then underwent injections and was referred back for continued therapy that included therapeutic exercises, neuromuscular reeducation, myofascial release, joint mobilization and ultrasound.

Requested Services

Office visits, therapeutic procedures, myofascial release, joint mobilization, neuromuscular reeducation move, electrical stimulation, muscle testing, range of motion measurements, noninvasive ear/pulse oximetry, supplies and iontophoresis from 3/24/03 through 4/16/03.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a female who sustained a work related injury on ___. The ___ physician reviewer indicated that this patient had been receiving physical therapy for a left wrist injury and left carpal tunnel release. The ___ physician reviewer explained that the physical therapy was discontinued on 1/13/03 due to the patient's complaints of increased pain and swelling.

The ___ physician reviewer noted that after further treatment the patient was referred back to physical therapy after 2/26/03. The ___ physician reviewer explained that prior to 1/13/03 the patient was making progress with the physical therapy. The ___ physician reviewer noted that although the patient was making progress, she was still 25-40% below normal. The ___ physician reviewer explained that the patient began physical therapy again on 3/19/03. The ___ physician reviewer indicated that by 4/4/03 the patient's left wrist range of motion had improved to near normal and that the patient's strength had still remained 30-40% below normal. The ___ physician reviewer explained that the patient was making progress with strength, range of motion in left wrist and required continued skilled physical therapy for continued improvement. The ___ physician reviewer also explained that although the patient was still having pain by 4/16/03, the physical therapy provided between 3/24/03 and 4/4/03 was medically necessary because the patient showed progress with range of motion and strength in the left wrist. Therefore, the ___ physician consultant concluded that the office visits, therapeutic procedures, myofascial release, joint mobilization, neuromuscular reeducation move, electrical stimulation, muscle testing, range of motion measurements, noninvasive ear/pulse oximetry, supplies and iontophoresis from 3/24/03 through 4/16/03 were medically necessary to treat this patient's condition.

Sincerely,