

MDR Tracking Number: M5-04-0568-01

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 09-22-03.

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 \$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 unlisted evaluation and management service was found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

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 date of service 07-22-03 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 22nd day of January 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

NOTICE OF INDEPENDENT REVIEW DECISION

Amended Letter
Note: Dates of service

January 2, 2004

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: MDR Tracking #: M5-04-0568-01
IRO Certificate #: IRO 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 patient sustained a repetitive injury reported on ___, while working as a typist. She complained of neck pain radiating into her right shoulder along with numbness to both hands and arms. She saw a chiropractor for treatment and therapy. Electromyography and nerve conduction velocity testing performed 11/14/01 were consistent with bilateral carpal tunnel syndrome. The denied service listed placed her at maximum medical improvement on 05/15/03 with 9% impairment.

Requested Service(s)

Unlisted E & M service (Independent Medical Examination-IME) on 07/22/03

Decision

It is determined that the unlisted E & M service (Independent Medical Examination-IME) on 07/22/03 was medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient has undergone an intensive treatment program since her injury. She was seen for an initial designated doctor examination (DDE) on 12/03/02 and found not to be at maximum medical improvement (MMI) and continuation of treatment was recommended. An independent medical examination (IME) was performed on 12/17/02 and confirmation of carpal tunnel syndrome was made with recommendation of repeat electro-diagnostic studies. Referral to a hand specialist and possible functional capacity evaluation (FCE) to determine her true work status was recommended. On 05/15/03, the patient was seen once again for a DDE by the same doctor she saw on 12/17/02. This examination revealed that in his opinion the patient was at MMI with no impairment.

The report from the designated doctor was received and reviewed by the treating doctor. In the report, there were inconsistent findings. The designated doctor did not utilize the range of motion model for the wrist. He noted that while conversing with the patient, full wrist flexion and extension were obtained which was not what the patient reported occurring during the examination. This evaluation was performed by another doctor. Based on the documented medical record provided, the IME was medically necessary. Therefore, it is determined that the unlisted E & M service (Independent Medical Examination-IME) on 07/22/03 was medically necessary.

Sincerely,