

MDR Tracking Number: M5-04-0786-01

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 11-13-03.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the therapeutic procedures, ultrasound therapy, group therapeutic procedures, physical medicine treatment and office visits were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service 12-02-02 through 12-23-02 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 19<sup>th</sup> day of February 2004.

Debra L. Hewitt  
Medical Dispute Resolution Officer  
Medical Review Division  
DLH/dlh

**IRO Certificate #4599**

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

February 16, 2004

**Re: IRO Case # M5-04-0786**

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, Rule 133.308 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 IROs, 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 Certified in Orthopedic Surgery, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. 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 determination of the \_\_\_ reviewer who reviewed this case, based on the medical records provided, is as follows:

#### History

The patient is a female who reported a repetitive stress injury to both upper extremities. The patient was diagnosed with bilateral carpal tunnel syndrome, bilateral cubital tunnel syndrome, multiple trigger points in the cervical spine, and bilateral deQuervain's tenosynovitis. The patient underwent numerous treatments including physical therapy, steroid injections into the carpal tunnel, first extensor compartment, and cubital tunnel. Ultimately she underwent surgical treatment of her left deQuervain's tenosynovitis and her left cubital tunnel syndrome. She also received multiple trigger point injections into her neck. The patient reported her initial date of injury as \_\_\_. Multiple nerve conduction studies have shown no abnormalities. MRIs of the neck and elbow were also negative. Postoperatively, the patient received 12 physical therapy visits. Multi-modal therapy from 12/2/02 through 12/23/02, described as "post injection therapy" has been denied as unnecessary.

#### Requested Service(s)

Therapeutic proc, ultrasound, grp ther procs, phys med tx, ovs 12/2/02 – 12/23/02

#### Decision

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

#### Rationale

Post injection therapy is not an accepted treatment modality for someone who has failed similar physical therapy. At the time the patient received the steroid injections, she certainly had had enough physical therapy to be adequately trained in a home exercise program. Therefore, post injection therapy including office visits and modalities is not medically necessary and is not standard practice.

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