MDR Tracking Number: M5-04-0888-01

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 November 24, 2003.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the majority of 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 application of surface neurostimulator, myofascial exercises, training daily living activities, hot/cold pack therapy, joint mobilization, therapeutic exercises, ultrasound, unlisted supplies, office visits and iontophoresis were found to be medically necessary for 01-13-03 through 02-17-03. The services listed above were not found to be medically necessary for 02-18-03 through 03-05-03. The respondent raised no other reasons for denying reimbursement for services listed above.

This findings and decision is hereby issued this 20th day of February 2004.

Patricia Rodriguez
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 01/13/03 through 02/17/03 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 20th day of February 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division
PR/pr

February 18, 2004

NOTICE OF INDEPENDENT REVIEW DECISION
Amended Determination

RE: MDR Tracking #: M5-04-0888-01

___ 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 56 year-old female who sustained a work related injury on ___. The patient reported that while at work she lost her balance and fell causing injury to her left wrist, left arm, and back. An emergency department medical record dated 6/27/02 indicated that the differential diagnoses for this patient was reported to be thoracic or lumbar fracture, thoracic/lumbar strain, forearm fracture, and that the diagnosis for this patient was reported to be a left distal radius fracture left ulnar styloid fracture. The patient was placed in a cast and discharged. On 7/2/02 the patient underwent X-Rays of the lumbopelvic/lateral lumbars and left wrist. The report from this series indicated that the patient had moderated increase in lumbar lordosis, osteophyte formation throughout lumbar spine, enthesopathic changes at both crests, surgical clips between L5 and sacrum, and a fracture of the distal radial and ulnar styloid process. On 8/7/02 the patient was evaluated by an orthopedic surgeon and was treated with physical therapy up through 11/27/02. The patient had also been treated with lumbar epidural steroid injections as well as injections to the left wrist. On 10/31/02 the patient underwent electrodiagnostic studies that indicated signs of carpal tunnel syndrome of the left wrist. On 12/4/02 the patient underwent an ulna and median nerve decompression of the left wrist. On 1/3/03 the patient resumed physical therapy.

Requested Services
Application of surface neurostimulator, myofascial exercises, training daily living activities, hot/cold pack therapy, joint mobilization, therapeutic exercises, ultrasound, unlisted supplies, office visits and iontophoresis from 01/13/03 through 03/05/03.

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

Rationale/Basis for Decision
The ___ physician reviewer noted that this case concerns a 56 year-old female who underwent left ulnar/radial nerve decompression surgery on ___. The ___ physician reviewer indicated that the patient began physical therapy on 1/3/03. The ___ physician reviewer explained that by 1/30/03 the patient had improved range of motion in the left wrist demonstrated by an increase in flexion to 35 degrees from 15, extension up to 40 degrees from 10, and grip strength increased to 25 pounds from 20. The ___ physician reviewer also explained that a progress note dated 2/17/03 indicated that the patient's condition had not changed. The ___ physician reviewer indicated that the patient continued to complain of pain and was performing a daily home exercise program, however, the patient's condition had plateaued in physical therapy. The ___ physician reviewer explained that although the patient had plateaued in physical therapy by 2/17/03, the patient still required pain management and a home exercise program. Therefore, the ___ physician consultant concluded that the application of surface neurostimulator, myofascial exercises, training daily living activities, hot/cold pack therapy, joint mobilization, therapeutic exercises, ultrasound, unlisted supplies, office visits and iontophoresis from 01/13/03 through 2/17/03 were medically necessary to treat this patient's condition. However, the ___ physician consultant concluded that the application of surface neurostimulator, myofascial exercises, training daily living activities, hot/cold pack therapy, joint mobilization, therapeutic exercises, ultrasound, unlisted supplies, office visits and iontophoresis from 2/18/03 through 3/5/03 were not medically necessary to treat this patient's condition.

Sincerely,