

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 3-4-04.

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 ultrasound therapy, therapeutic exercises, office visits, hot/cold pack therapy, manual therapy and electrical stimulation from 8-22-03 through 9-9-03 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 from 8-22-03 through 9-9-03 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 30th day of July 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

DA/da

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

July 26, 2004

Re: IRO Case # M5-04-1971-01

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:

Medical Information Reviewed

1. Table of disputed service 12/30/02 – 10/13/03
2. Explanation of benefits
3. Review from carrier 9/29/03
4. Intra-articular gadolinium injection to the right wrist report 8/4/03
5. Position statement and clinic notes from treatment center
6. Office notes

History

It appears from the documentation provided that the patient sprained her right wrist on _____. It was described as a hyper extension injury. The patient initially sought care from an M.D., who referred the patient to a D.C. for chiropractic treatment. MRI studies on 8/14/03 were negative. The patient had continued complaints, however, of pain, mainly at the radial aspect of her wrist.

Requested Service(s)

Ultrasound therapy, therapeutic exercises, office visits, hot/cold pack therapy, manual therapy, electrical stimulation 8/22/03 – 9/9/03

Decision

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

Rationale

The patient presented with chronic wrist pain approximately two months after her injury. Since x-rays and MRI were negative, the patient was sent for physical medicine treatment three times a week for four weeks. At that point, the patient should have been sent for more sophisticated examination with a hand surgeon. Evaluation could have included diagnostic arthroscopy or fluoroscopy. A negative MRI does not rule out ligament pathology, and a recent report of the *Journal of hand Surgery* has reported a 30% false negative rate on such MRIs. Physical therapy was not appropriate at the time it was prescribed because of the chronicity of the patient's complaints and lack of surgical evaluation.

According to the Requestor in this case, the physical therapy apparently was effective. If the patient had a simple sprain of the wrist, however, the fact that her symptoms improved represents the natural history of a simple sprain. Therefore, it would not have been the physical therapy that relieved the patient's pain, but the natural history of a simple sprain.

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