

THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:
SOAH DOCKET NO. 453-04-8367.M5

MDR Tracking Number: M5-04-2406-01

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 04-02-04.

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 joint mobilization, therapeutic exercises, manual therapy technique, office visits, massage therapy, work hardening, work hardening each additional hour, neuromuscular re-education and muscle testing 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 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 07-29-03 to 12-01-03 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Findings and Decision is hereby issued this 16th day of July 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

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NOTICE OF INDEPENDENT REVIEW DECISION

June 10, 2004

Re: IRO Case # M5-04-2406-01 amended 7/16/04

Texas Worker's Compensation Commission:

Envoy Medical Systems, LP (Envoy) 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, Rule133.308 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 Envoy for an independent review. Envoy has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, Envoy 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 a Doctor of Chiropractic who is licensed by the State of Texas, 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 Envoy 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 Envoy reviewer who reviewed this case, based on the medical records provided, is as follows:

Medical Information Reviewed

1. Table of disputed service 4/21/03 – 5/20/03
2. Explanation of benefits
3. Letter of medical necessity 5/7/04
4. SOAP notes from treating D.C.
5. Radiological report of cervical spine 9/13/03
6. MRI of cervical spine report 9/3/03
7. Report 10/1/03
8. MRI of lumbar spine report 8/5/03
9. FCE reports 10/23/03, 11/11/03, 12/9/03
10. Work hardening notes

History

The patient injured her right wrist, elbow and shoulder in ___ after repetitive movement while typing. X-rays were taken, and the patient was treated with medication, injections

and chiropractic treatment.

Requested Service(s)

Elbow orthosis, OV(99213), ultrasound, elect stim unattend, hot cold pack ther, electrodes pair, myofas rel 4/21/03 – 5/20/03

Decision

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

Rationale

The patient had had extensive conservative treatment for a diagnosed lateral epicondylitis and shoulder impingement without relief of symptoms or improved function prior to the dates in dispute. The patient's symptoms had been chronic and ongoing for over a year prior to the disputed dates, without relief from conservative treatment. The documentation provided for this review fails to show any attempt to try to ergonomically correct the source or cause of the problem at work. As long as the patient continues to do this type of work, without ergonomic correction and education, she will continue to have chronic problems associated with repetitive movements. Myofascial pain syndromes usually respond very well to appropriate conservative treatment and ergonomic correction at the work place. The D.C.'s treatment over the course of a year failed to be beneficial to the patient. The failure of therapy does not establish a medical rationale for additional non-effective therapy.

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