

MDR Tracking Number: M5-04-3062-01

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 April 29, 2002.

The 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 office visits (99214, 99213, 99212, 99211), unlisted procedure (97139), supplies/materials (99070-PH), therapeutic exercises (97110), whirlpool (97022), ultrasound (97035), and massage therapy (97124) 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 Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the treatment listed above were not found to be medically necessary, reimbursement for dates of service from 11-19-01 to 02-14-02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 30<sup>th</sup> day of August 2004.

Patricia Rodriguez  
Medical Dispute Resolution Officer  
Medical Review Division

PR/pr

## **MEDICAL REVIEW OF TEXAS**

**[IRO #5259]**

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### **NOTICE OF INDEPENDENT REVIEW DETERMINATION**

**REVISED 8/26/04**

TWCC Case Number:	
MDR Tracking Number:	M5-04-3062-01
Name of Patient:	
Name of URA/Payer:	
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	

August 2, 2004

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

CLINICAL HISTORY

Available information suggests that this patient reports experiencing a bilateral wrist injury when she slipped and fell while carrying a box at work on \_\_\_\_\_. She appears to have presented initially for medical care with a Dr. L but no records of this are provided for review. She also appears to be seen for conservative treatment with Dr. H, Dr. A, and

Dr. P following injury but no documentation is provided prior to 11/19/01. Interim treatment is not disclosed. The patient also appears to have multiple examinations by a Dr. R, for complaints of lower back pain that appears to have no relation to these compensable injuries. The patient is said to undergo bilateral wrist surgery with a Dr. B on 01/14/02 but no documentation from this is submitted for review. In addition, no post surgical therapy recommendations appear to be submitted by this hand surgeon. The patient appears to undergo several months of passive and active therapy for pre and post surgical carpal tunnel syndrome.

#### REQUESTED SERVICE(S)

Determine medical necessity for office visits (99214, 99213, 99212, 99211), unlisted procedure (97139), supplies/materials (99070-PH), therapeutic exercise (97110), whirlpool (97022), ultrasound (97035) and massage therapy (97124) for period in dispute 11/19/01 through 02/14/02.

#### DECISION

Denied.

#### RATIONALE/BASIS FOR DECISION

Medical necessity for these ongoing treatments and services (11/19/01 through 02/14/02) **are not supported** by available documentation. Ongoing therapeutic modalities of this nature suggest little potential for further restoration of function or resolution of symptoms at three to four years post injury. Without specific post surgical recommendations made by treating hand surgeon, medical necessity for this late phase intervention cannot be reasonably determined.

1. Philadelphia Panel Evidence-Based Clinical Practice Guidelines on Selected Rehabilitation Physical Therapy, Volume 81, Number 10, October 2001.
2. Bigos S., et. al., AHCPR, Clinical Practice Guideline, Publication No. 95-0643, Public Health Service, December 1994.
3. Harris GR, Susman JL: "*Managing musculoskeletal complaints with rehabilitation therapy*" [Journal of Family Practice](#), Dec, 2002.
4. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Mercy Center Consensus Conference, Aspen Publishers, 1993.
5. Ozatas O, *Ultrasound therapy effect in carpal tunnel syndrome*, Arch Phys Med Rehabil – 01-Dec-1998; 79(12): 1540-4.

6. Akalin E, *Treatment of carpal tunnel syndrome with nerve and tendon gliding exercises*, Am J Phys Med Rehabil – 01-feb-2002; 81(2): 108-13.
7. Piehl JH, *Which treatments for carpal tunnel syndrome are beneficial?*, Am Fam Phys, Vol 68, No. 4 – 15-Aug-2003.
8. Gerr F, et al, *Aerobic Exercise, Median Nerve Conduction and Reporting the Study Results*, J Occ & Environ Med, Vol. 44, No. 4 – Apr-2002.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials.

No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned individual. These opinions rendered do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.