

MDR Tracking Number: M5-04-4115-01

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 July 29, 2004.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. 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 was the only issue** to be resolved. The office visits and manual therapy technique from 01-16-04 through 03-23-04 **were** found to be medically necessary. The chiropractic manual treatment, electrical stimulation unattended, ultrasound, therapeutic processes and massage from 01-16-04 through 03-23-04 **were not** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

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 01-16-04 through 03-23-04 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 5th day of November 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division
PR/pr

NOTICE OF INDEPENDENT REVIEW DECISION

October 5, 2004

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking #: M5-04-4115-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. TMF's health care

professional has signed a certification statement stating 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 the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient sustained a work-related injury on ____ when he was pushing panel with a hydrolic jack and slipped on oil and fell onto his left hand. He sustained a fracture of his distal phalanx of the left middle finger. The patient underwent surgery followed by another surgery on 09/09/2003 to correct the deformity to the left middle finger. The patient received chiropractic care as part of his treatment

Requested Service(s)

97710-Therapeutic procedures, office visits, **97140**-Manual therapy technique, **97124**-massage, **97710**-therapeutic processes, **98940**-chiropractic manual treatment, **97035**-ultrasound, and **97014**-electrical stimulation unattended provided from 01/16/2004 through 03/23/2004.

Decision

It is determined that the office visits and manual therapy technique were medical necessary to treat this patient's medical condition from 01/16/2004 through 03/23/2004. However, the chiropractic manual treatment, electrical stimulation unattended, ultrasound, therapeutic processes, and massage from 01/16/2004 through 03/23/2004 were not medically necessary to treat this patient's medical condition.

Rationale/Basis for Decision

The office visits were medically necessary in this case for the evaluation of the patient's treatment. The manual therapy techniques were medically necessary due to the documented reductions in the patient's range of motion to the injured finger.

The use of chiropractic manipulation and electrical stimulation were not medically necessary in this case. The hand surgeon for post-surgical rehabilitation referred the patient for the left hand rehabilitation only; the surgeon did not indicate problems related to the cervical region in his prescription for therapy therefore it is not medically necessary.

The use of ultrasound was not medically necessary to treat this patient's medical condition. Van der Windt et al conducted a review to evaluate the effectiveness of ultrasound therapy in the treatment of musculoskeletal disorders. The authors conclude that, as of yet, there seems to be little evidence to support the use of ultrasound therapy in the treatment of musculoskeletal disorders. (*Van der Windt DA, et al, "Ultrasound therapy for musculoskeletal disorders: a systematic review", Pain. 1999 Jun;81(3):257-71*)

Medical documentation of massage and therapeutic exercise for rehabilitation of a middle finger deformity of the left hand did not show a clinical indication for the treatments, and no significant changes in the patient's condition were noted, therefore, these therapies were not medically necessary to treat this patient's medical condition.

Sincerely,