

**THIS DECISION HAS BEEN APPEALED. THE FOLLOWING
IS THE RELATED SOAH DECISION NUMBER:**

SOAH DOCKET NO. 453-05-3145.M5

MDR Tracking Number: M5-04-4366-01

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 August 25, 2004.

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, massage therapy, therapeutic exercises, and ultrasound therapy were not found to be 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 was the only issue** to be resolved. As the office visits, massage therapy, therapeutic exercises, and ultrasound therapy were not found to be medically necessary, reimbursement for dates of service from 1/27/04 thru 2/16/04 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 1st day of November 2004.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

NOTICE OF INDEPENDENT REVIEW DECISION

October 22, 2004

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 #: M5-04-4366-01
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 43 year-old female injured her wrists on ___ after performing repetitive movements at work. Her diagnosis is carpal tunnel syndrome. She has been treated with therapy and medications.

Requested Service(s)

Office visits (99214/99213), massage therapy (97124), therapeutic exercise (97110), ultrasound therapy (97035) for dates of services 01/27/04 through 02/16/04

Decision

It is determined that there is no medical necessity for the office visits, massage therapy, therapeutic exercise, and ultrasound therapy for dates of services 01/27/04 through 02/16/04.

Rationale/Basis for Decision

Medical record documentation does not indicate the necessity for the office visits, massage therapy, therapeutic exercise, and ultrasound therapy for the dates in question. Frequency, type and duration of services must be reasonable and consistent with the standard of the health care community. Physical therapy guidelines as well as chiropractic treatment guidelines for carpal tunnel syndrome indicate a fading of treatment frequency from up to 3 visits per week to 1 or less plus self-directed home therapy for a total treatment time of up to 8 weeks. This patient has been treated since her injury with no indication of an end-point. Continued treatment is expected to improve the patient's condition and initiate restoration of function. If treatment does not produce the expected positive results, it is not reasonable to continue the course of treatment and is therefore not medically necessary to treat this patient's medical condition.

Sincerely,