



Texas Department of Insurance, Division of Workers' Compensation
 7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

PREVAILING PARTY DETERMINATION

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address: Coastal Spine Medical Center 5327 S. McColl Road Edinburg, Texas 78539	MDR Tracking No.: M5-05-2859-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Insurance Company Box 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Division assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the requestor and respondent.

Consistent with the requirements in Rule 133.308, the Division has reviewed the IRO decision and determined:

- The requestor is the prevailing party.
- The respondent is the prevailing party.

PART III: ADDITIONAL INSTRUCTIONS

The parties are instructed to review the IRO decision and take appropriate action. For any services that may have been found to be medically necessary, the insurance carrier is instructed to process those services through their bill review and payment processes, including issuing any additional amounts due consistent with the established fee guidelines. If the requestor was the prevailing party, the carrier must refund the amount of the IRO fee to the requestor within 30-days of receipt of this order.

Issued by:

Authorized Signature	Typed Name	09-08-05 Date of Decision
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7600 Chevy Chase, Suite 400
Austin, Texas 78752
Phone: (512) 371-8100
Fax: (800) 580-3123

NOTICE OF INDEPENDENT REVIEW DECISION

Date: September 7, 2005

To The Attention Of: DWC
7551 Metro Center Drive, Suite 100, MS-48
Austin, TX 78744-16091

RE: Injured Worker: _____
MDR Tracking #: M5-05-2859-01
IRO Certificate #: IRO 5263

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

Forté has performed an independent review of the proposed 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 an Orthopedic Surgeon reviewer (who is board certified in Orthopedic Surgery) who has an ADL certification. The reviewer 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 for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- Medical documents of Coastal Spine Medical Center
- EMG/NCV study report of Texas Neurodiagnostic Associates, Inc. dated 6/30/04

Submitted by Respondent:

- None submitted

Clinical History

The claimant has complaints of pain and numbness of the upper extremities allegedly due to a compensable injury on _____. The claimant reportedly sustained injury to both hands and right elbow while changing a bit on a drill. History is consistent with a repetitive use injury (RUI).

Requested Service(s)

Office visits (99212, 99214), massage (97124), ultrasound (97035), aquatic therapy (97113), neuromuscular re-education (97112), manual therapy technique (97140), therapeutic exercises (97110), Biofreeze (E1399), and electrical stimulation (G0283) for dates of service 7/6/04 to 8/19/04

Decision

I agree with the carrier that the requested intervention is not medically necessary.

Rationale/Basis for Decision

Standard of care for treatment of nerve entrapment syndromes includes avoidance of aggravating repetitive microtrauma, splinting, injections, and medications. There is no clinical documentation to support the use of ultrasound, aquatic therapy, neuromuscular re-education, manual therapy techniques, therapeutic exercises or electrical stimulation in the management of a nerve entrapment syndrome. Documentation further indicates mild nerve entrapment findings on EMG/NCV study performed in June. Findings are consistent with self limited conditions that would, within reasonable medical probability, resolve with usual conservative measures of treatment listed above. The items in dispute would be anticipated to exacerbate, not relieve, a nerve entrapment syndrome. The documentation does not support that the requested interventions are medically necessary.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to DWC via facsimile or U.S. Postal Service from the office of the IRO on this 7th day of September 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder