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

SOAH DOCKET NO. 453-03-3464.M5

MDR Tracking Number: M5-03-0966-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 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 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 offices visit, electrical stimulation, myofascial release, joint mobilization, therapeutic exercises, group therapy procedure, report and analgesic balm 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 offices visit, electrical stimulation, myofascial release, joint mobilization, therapeutic exercises, group therapy procedure, report and analgesic balm fees were the only fees involved in the medical dispute to be resolved. As the treatment was not found to be medically necessary, reimbursement for dates of service from 12/1/02 to 5/30/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 9th day of May 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

February 28, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-0966-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by

the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel. The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 35 year-old female who sustained a work related injury on ___. The patient reported that while at work she was placing chicken carcasses on a machine that puts the chickens into a line. The patient reported that she had to lift the birds with both arms, and while doing so she quickly lifted some birds and began to feel a dull onset of pain that gradually became worse over several days of working. The patient had X-Rays of her left shoulder and was diagnosed with tendonitis of the shoulder. The patient has been treated with pain medications and physical therapy.

Requested Services

Electrical stimulation, myofascial release, joint mobilization, therapeutic exercises, group therapy procedure, office visits, special reports, and analgesic balm from 12/1/02 through 5/30/02.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is upheld.

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that the patient sustained a work related injury to her shoulder on ___. The ___ chiropractor reviewer also noted that the patient was treated with pain medications, physical therapy, and chiropractic care. The ___ chiropractor reviewer noted that the patient did not show any significant improvement after the initial two months of care. The ___ chiropractor reviewer explained that the documents provided indicate that the patient was feeling worse with the treatments. The ___ chiropractor reviewer noted that the patient was treated with mostly passive therapy. The ___ chiropractor reviewer explained that the patient could perform passive therapy at home once taught the exercises. The ___ chiropractor reviewer also explained that passive therapy is not the therapy of choice one year after the onset of a condition. The ___ chiropractor reviewer further explained that the patient had a solid trial of chiropractic care with minimal improvement. Therefore, the ___ chiropractor consultant concluded that the electrical stimulation, myofascial release, joint mobilization, therapeutic exercises, group therapy procedure, office visits, special reports, analgesic balm from 12/1/02 through 5/30/02 were not medically necessary to treat this patient's condition.

Sincerely,