MDR Tracking Number: M5-03-1126-01

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, 2003 and Commission Rule 133.305 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review 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 analgesic balms, massage therapy, mechanical traction, joint mobilization, cervical traction, myofascial release, diathermy and office visits 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 the analgesic balms, massage therapy, mechanical traction, joint mobilization, cervical traction, myofascial release, diathermy and office visits 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 1/21/02 through 11/14/02 is denied and the Division declines to issue an Order in this dispute.

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

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

May 7, 2003

Re: MDR #: M5-03-1126-01

___has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is Certified in Chiropractic Medicine.

Clinical History:
This male claimant sustained a work-related cervical injury on ___. Surgery was performed on 03/19/99, and treatment has been continuous since 10/16/97. The care the patient has currently been receiving is strictly passive modalities. He has continually marked a level of pain around a 6 or 7 from visit to visit.

Disputed Services:
Analgesic balms, massage therapy, mechanical traction, joint mobilization, cervical traction, myofascial release, diathermy and office visits during the period of 01/21/02 through 11/14/02.

Decision:
The reviewer agrees with the determination of the insurance carrier. The reviewer is of the opinion that the services rendered were not medically necessary in this case.

Rationale for Decision:
The documentation presented for review indicates that this patient has shown no improvement in his pain scale from these passive treatments received during this approximately 10-month period.

I am the Secretary and General Counsel ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.