MDR Tracking Number: M5-03-1460-01

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 chiropractic treatments 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 chiropractic treatments 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 2/5/02 through 8/23/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 27th day of June 2003.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

Re: Medical Dispute Resolution
MDR #: M5-03-1460-01
IRO #: 5055

___ 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 female claimant reported a repetitive stress injury to the right hand and shoulder on ___. She had had a variety of care, including chiropractic, physical therapy, cervical ESI's, shoulder injections, pain management, trigger point injections, shoulder surgery, and medications.

Right shoulder arthroscopy, subacromial decompression, and a debridement of posterior labral tear were performed on 08/30/02. On 02/27/03, a shoulder manipulation under anesthesia (MUA), coupled with physical therapy applications, was performed. The patient has been under chiropractic care since 12/08/99.

Disputed Services:
Chiropractic services during the period of 02/05/02 through 08/23/02.

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

Rationale for Decision:
Continued passive therapeutic applications utilized in the treatment of this patient's condition are no longer warranted. The records provided for review indicate that she has been seen by the treating provider since ___ on nearly 200 occasions. This is excessive and not warranted, from the documentation submitted for review.

The patient has had a myriad of invasive/conservative treatment applications since her injury, with no documented benefit to her functional status. The records show continued uni-disciplinary treatment application without an active patient-driven treatment paradigm.

It remains vital to the management of this patient that a continued multi-disciplinary treatment algorithm remains in existence, with a concentration on active, patient-driven applications. At this point, functional baseline data should be maintained so that any imposed treatment trial can be compared to the baseline for any positive therapeutic value.

This patient's progress does not warrant passive therapeutics when treatment her medical condition. Due to the extended period of time she has remained away from industry, it is vital to determine the relevance of any psychosocial deficits. Activation of therapeutics with a distinct behavioral focus may be a feasible treatment option.

The aforementioned information has been taken fro the following guidelines of clinical practice:

- *Criteria for Shoulder Surgery*, Washington State Department of Labor and Industries; 2002, Mar., 4p.
- *Guidelines for Psychiatric and Psychological Evaluation of Injured or Chronically Disabled Workers*. Washington State Department of Labor and Industries; 1999, Jun., 10 p.
- Overview of Implementation of Outcome Assessment Case Management in the Clinical Practice. Washington State Chiropractic Association; 2001, 54 p.

I am the Secretary and General Counsel of ___ 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.

Sincerely,