MDR Tracking Number: M5-03-1617-01

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 adverse determination that the aquatic therapy, massage therapy, electrical stimulation and office visits 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 Division has determined that the aquatic therapy, massage therapy, electrical stimulation and office visits 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 7/8/02 through 8/13/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 3rd day of July 2003.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

June 30, 2003

MDR Tracking Number: M5-03-1617-01
IRO Certificate # 5259

An independent review of the above-referenced case has been completed by a medical chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY

Based on available documentation, this individual was apparently injured at work on ___ as a result of a fall while carrying heavy trash bags. The claim for injuries appears to involve her left shoulder, left elbow, left wrist, and lower back. No initial medical evaluation appears to have been performed. The patient appears to have presented for chiropractic examination on 08/28/01 with ___. Conditions are described as acute sprain/strain of the cervical spine, thoracic spine, lumbar spine, and affected extremities. No other chiropractic notes or reports are submitted until 07/08/02. An MRI performed 09/27/01 suggests impingement syndrome and rotator cuff tear to the left shoulder. Cervical and lumbar x-rays from 09/19/01 suggest essentially normal findings with some degenerative spondylotic changes throughout the lumbar spine. A radiographic biomechanical report is also submitted for the cervical and lumbar spine only. Chiropractic treatment notes are submitted for 07/08/02 through 08/13/02 only. Chiropractic consultation note submitted 07/08/02 suggests that the patient has suffered an exacerbation of previous shoulder pain and is diagnosed with rotator cuff syndrome only. The patient was apparently seen by a ___ for a series of injections, but no reports of this are available for review. The patient is finally referred for orthopedic evaluation on 07/09/02 with ___. These notes suggest that injections provided by ___ have been the only source of relief for her pain. ___ confirms low back pain, left shoulder pain, and rotator cuff syndrome. Neck, upper back, and lower extremities are found to be within normal limits with no instability and no soft tissue or articular abnormality. Medications are provided and patient is continued with rehabilitation. Chiropractic notes submitted from 07/08/02 through 08/13/02 suggest that this patient is also attended by a ___ and a ___ but no reports from these providers are provided for review. Multiple passive and active therapies appear to be provided for knee instability, shoulder pain, neck pain, and low back pain. Interestingly, chiropractor evaluates patient on multiple occasions having low back pain and ridiculopathy; however, no advanced imaging is performed to conform this suspected complication.

REQUESTED SERVICE (S)

Determine medical necessity for aquatic therapy; massage therapy, electrical stimulation, and office visits for dates of service in dispute (07/08/02 thru 08/13/02).

DECISION

There is a considerable amount of conflicting information concerning injuries initially reported and conditions objectively confirmed. There is little objective evidence supporting treatment for conditions other than shoulder rotator cuff syndrome and low back sprain/strain that are casually related to work related accident of ___. At nearly one-year post injury, there is little supporting evidence that any of the disputed services have significant potential for restoration of function or resolution of painful symptoms as related to compensable injury. Medical necessity for these disputed services is not supported by the documentation provided.

RATIONALE/BASIS FOR DECISION

This level, frequency, and duration of care for rotator cuff syndrome and low back sprain/strain, at ___ post injury, exceeds TWCC spine and upper extremity guidelines established for conditions of this nature.

In addition, standards of care suspected rotator cuff tear and lumbar discopathy would require specialty consultation, surgical referral or objective/advanced imaging within the first 30 to 60 days if response to conservative care is limited. As there is little documentation of patient progress during the first 10 months of intervention, ongoing care at these levels cannot be supported. It is also reported that this provider has been deleted from the approved doctor list (ADL) established by the TWCC. If this 'deleted' status is confirmed, it would appear question this provider's qualifications to render appropriate care to injured workers in this state.