MDR Tracking Number: M5-03-2092-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General 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 dispute was received on April 23,2003. The requestor withdrew the fee issues for date of service 01-21-03.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The therapeutic activities, therapeutic procedures, special supplies, office visits and physical performance test from 01-02-03 to 02-13-03 were found to be medically necessary. The IRO agrees with the previous determination that the hot or cold packs, unattended electrical stimulation, ultrasound, phonophoresis, miscellaneous durable medical equipment and myofasical release were not medically necessary. The respondent raised no other reasons for denying reimbursement of therapeutic activities, therapeutic procedures, special supplies, office visits and physical performance test from 01-02-03 to 02-13-03.

This Finding and Decision is hereby issued this 12th day of December 2003.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this Order. This Order is applicable to dates of service 01-02-03 through 02-13-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 12th day of December 2003.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

GR/gr

NOTICE OF INDEPENDENT REVIEW DECISION

July 7, 2003

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
4000 South IH-35, MS 48
Austin, TX 78704-7491

RE: MDR Tracking #: M5-03-2092-01
IRO Certificate #: IRO4326

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

___ has performed an independent review of the rendered 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 a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in «Healthcare_Professional». ___'s health care professional 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.

Clinical History

This patient sustained an injury to her lumbar and cervical areas on ___ when she picked up a water-filled bucket. She reported feeling immediate deep, burning pain up the right shoulder and neck. A cervical MRI dated 11/26/02 revealed small central disc bulge at C3-4 with minimal foraminal narrowing on the left due to facet hypertrophy.

Requested Service(s)

Office visits, hot/cold packs, electrical stimulation (unattended), ultrasound, therapeutic activities, special supplies, miscellaneous durable medical equipment (DME), myofascial release, phonophoresis, therapeutic procedures, and physical performance tests from 01/02/03 through 02/13/03

Decision

It is determined that therapeutic activities, therapeutic procedures, special supplies, office visits, and physical performance tests from 01/02/03 through 02/13/03 were medically necessary to treat this patient's condition. However, it is determined that the hot/cold packs, unattended electrical stimulation, ultrasound, phonophoresis, miscellaneous durable medical equipment (DME), and myofascial release from 01/02/03 through 02/13/03 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient began seeing a chiropractor after the initial injury and was diagnosed with cervical displacement, cervical sprain, thoracic sprain, and headache. The patient was referred for physical therapy and her initial evaluation revealed slightly reduced cervical ranges of motion (ROM) and global 4/5 muscle strength in the bilateral upper extremities. The physical therapy re-evaluation on 01/23/03 revealed that the patient's ROM were improved over the initial examination findings and increased strength was noted in shoulder flexion, extension, and in the rhomboid muscles bilaterally.The patient underwent a functional capacity evaluation (FCE) on 01/23/03 that revealed her required physical level for her employer was heavy and she was currently functioning at the light physical demand level (PDL). Another FCE report dated 01/23/03 revealed the patient's job required her to function at the light PDL and she was functioning at that level per the 1/23/03 FCE.

The patient underwent another re-evaluation on 02/13/03 and her ROM had not improved substantially over her 01/23/03 physical therapy evaluation. The muscle testing revealed normal strength in the upper extremities.

The Philadelphia Panel indicated that for neck pain, therapeutic exercises were the only intervention with clinically important benefit. There was good agreement with this recommendation from practitioners (93%). For several interventions and indications (e.g., thermotherapy, therapeutic ultrasound, massage, electrical stimulation), there was a lack of evidence regarding efficacy. Reference: "Philadelphia Panel Evidence-Based Guidelines on Selected Rehabilitation Interventions for Neck Pain". *Phys Ther*. 2001;81:1701-1717.

Sincerely,