NOTICE OF INDEPENDENT REVIEW DECISION

Date: September 5, 2003

RE: MDR Tracking #: M5-03-2687-01
IRO Certificate #: **5242**

_____ 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 proposed 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 Chiropractic physician reviewer. The Chiropractic physician reviewer 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

According to the supplied documentation, it appears that Mr. _____injured his low back and shoulder while trying to stop a 100 lb sack from falling on 10/08/2001 while at work. The claimant saw the company doctor who prescribed medications and sent him back to work. In 01/2002, the claimant changed treating doctors to _____. The daily notes move forward to 07/01/2002 in which it reports the claimant is post-operative for his left shoulder and is undergoing active rehabilitation. The notes from 07/01/2002 – 12/20/2002 show a mixed use of passive and active modalities. The claimant also underwent epidural steroid injections in his lumbar spine as well as facet injections in his cervical spine. Several functional capacity exam's were performed, which put the claimant under his very heavy work level. The claimant was given an impairment rating in January 2003. The documentation ends here.

Requested Service(s)

Please review and address the medical necessity of the outpatient services including neuromuscular re-education, kinetic activities, office visits with manipulation, therapeutic procedures, myofascial release, analysis of computer data, physical performance testing, special reports, ultrasound, physical medicine treatment and neuromuscular stimulator rendered between 07/01/2002 through 12/20/2002.

Decision

I agree with the insurance provider that the services rendered between 07/01/2002 through 12/20/2002 including neuromuscular re-education, kinetic activities, office visits with manipulation, therapeutic procedures, myofascial release, analysis of computer data, physical performance testing, special reports, ultrasound, physical medicine treatment and neuromuscular stimulator were not medically necessary.

Rationale/Basis for Decision

The objective documentation supplied showed that the claimant had begun care in January 2002 and was not contested until 07/01/2002. This trial of 6 months of care should have been an adequate amount of time to see if conservative methods would help decrease the claimant's complaints and help return him to work. The active and passive care that was utilized did not help the claimant enough to return to work and continued to document enough pain to keep him from work. This obviously shows that the care this person was receiving from 01/2002 – 06/30/2002 was not working and therefore should have been discontinued for another treatment protocol. The records supplied do no objectively support the listed therapies above and are not supported by current medical standards.