MDR Tracking Number: M5-02-2918-01

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, 2002 and Commission Rule 133.305 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 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 the therapies (myofacial release with mobilization and or massage and or percussion) rendered were not medically necessary.

Based on review of the disputed issues within the request, the Division has determined that therapies (myofacial release with mobilization and or massage and or percussion) fees were the only fees involved in the medical dispute to be resolved. As the treatment, (therapies- myofacial release with mobilization and or massage and or percussion) was not found to be medically necessary, reimbursement for dates of service from 4/4/02 through 4/25/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 28th day of October 2002.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

NOTICE OF INDEPENDENT REVIEW DECISION

October 21, 2002

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

RE: MDR Tracking #: M5-02-2918-01
IRO Certificate #: 4326

___ 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 chiropractic care. ___ 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 47 year old female sustained a work related injury on ___ when she was lifting heavy trash bags and injured her neck and shoulder. On 03/06/01 the patient presented to the chiropractor's office complaining of neck and shoulder pain. Spinal sonography was performed on 11/08/01, which indicated mild nerve root inflammation at C3-C4 and mild facet inflammation at C3-C7. A thoracic ultrasound indicated a mild degree of costovertebral junction area inflammation at T1-T2 and T5-T6. Electrodiagnostics were performed on 11/08/01, which indicated a normal nerve conduction velocity study. The dermatomal somatosensory evoked potential (DSEP) study was abnormal indicating a right C8 radiculopathy. An MRI of the cervical spine was performed on 04/24/02 and reported to be within normal limits. The patient received chiropractic care from 04/04/02 through 04/25/02.

Requested Service(s)

The myofascial release, massage and percussion portions of the chiropractic care provided from 04/04/02 through 04/25/02.

Decision

It is determined that the myofascial release, massage and percussion portions of the chiropractic care provided from 04/04/02 through 04/25/02 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The medical record documentation indicates that the patient had a poor and unsustained response to care. Subjective pain levels varied from date to date indicating a clinical picture of unsustained positive response to treatment. In view of the subjective and objective responses to care, the chiropractic care was not efficacious. Therefore, it is determined that the myofascial release and massage portions of the chiropractic care provided from 04/04/02 through 04/15/02 was not medically necessary.

Sincerely,