

MDR Tracking Number: M5-04-1404-01

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 January 20, 2004.

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 electrical muscular stimulation unit, and supplies for the electrical muscular stimulation unit for date of service 05/01/03 **were found to be medically necessary**. The electrical muscular stimulation unit, supplies for the stimulation unit, and continued rental of the stimulator unit for dates of service 06/02/03 through 07/01/03 **were not found to be medically necessary**. The respondent raised no other reasons for denying reimbursement for the disputed issues.

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 date of service **05/01/03** 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 Decision and Order is hereby issued this 9<sup>th</sup> day of October 2004.

Marguerite Foster  
Medical Dispute Resolution Officer  
Medical Review Division  
MF/mf  
Enclosure: IRO decision

NOTICE OF INDEPENDENT REVIEW DECISION

March 30, 2004

Rosalinda Lopez  
Program Administrator  
Medical Review Division  
Texas Workers Compensation Commission  
7551 Metro Center Drive, Suite 100, MS 48  
Austin, TX 78744-1609

RE: Injured Worker:  
MDR Tracking #: M5-04-1404-01  
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) 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 TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO. TMF 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. TMF'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 TMF 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 on \_\_\_\_ while opening a stuck valve with a chain. He reported pain in his left shoulder, wrist, and neck. He saw a chiropractor for treatment and therapy. Electrodiagnostic testing performed 05/20/03 were consistent with moderate to severe left carpal tunnel syndrome.

#### Requested Service(s)

Hot/cold packs, electrical muscular stimulation unit, supplies for the stimulation unit, and continued rental of the stimulator unit from 05/01/03 through 07/01/03

#### Decision

It is determined that the hot/cold packs, electrical muscular stimulation unit, supplies for the stimulation unit, and continued rental of the stimulator unit from 05/01/03 through 05/09/03 were medically necessary to treat this patient's condition. However, hot/cold packs, electrical muscular stimulation unit, supplies for the stimulation unit, and continued rental of the stimulator unit from 05/10/03 through 07/01/03 were not medically necessary to treat this patient's condition.

#### Rationale/Basis for Decision

Review of the medical records indicates the dates of service occurred nearly three weeks post accident. Mercy Guidelines and Texas Chiropractic Guidelines suggest two week trials of care. This patient was treated from 04/22/03 until active rehabilitation was begun on 05/07/03. This was appropriate in this case, given the acute injury and the presence of an apparent overuse injury.

Over time, the use of passive modalities should be reduced. The electro muscle stimulator unit is a passive treatment oriented electrotherapy designed to reduce swelling and spasm. The unit is appropriate in an acute and into the sub-acute phases. A portion of the time in question falls into that time range. The application of hot/cold packs is appropriate as home therapy. Therefore, it is determined that the hot/cold packs, electrical muscular stimulation unit, supplies for the stimulation unit, and continued rental of the stimulator unit from 05/01/03 through 05/09/03 were medically necessary. However, hot/cold packs, electrical muscular stimulation unit, supplies for the stimulation unit, and continued rental of the stimulator unit from 05/10/03 through 07/01/03 were not medically necessary.

Sincerely,  
Gordon B. Strom, Jr., MD  
Director of Medical Assessment  
GBS:vn