

**THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

**SOAH DOCKET NO. 453-04-5927.M5**

MDR Tracking Number: M5-04-1721-01

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 2-12-04.

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 3/24/03 office visit **was found** to be medically necessary. The remaining office visits, myofascial release, ultrasound therapy, physical medicine treatment, and electrodes from 3/12/03 through 3/28/03 **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

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 3/12/03 through 3/28/03 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 22<sup>nd</sup> day of April 2004.

Regina Cleave  
Medical Dispute Resolution Officer  
Medical Review Division

RC/rc

**NOTICE OF INDEPENDENT REVIEW DECISION**

**Date:** April 15, 2004

**RE: MDR Tracking #:** M5-04-1721-01  
**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 reviewer who has an ADL certification. The 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**

The claimant apparently received injury to her neck, shoulder and upper extremities as she was performing occupational duties for her employer on \_\_\_. The said injury occurred due to alleged repetitive data entry operator duties.

Per the limited documentation available for this review, the follow up progress reports from the \_\_\_ denote claimant as chronic for problems; long term liver disease secondary to ETOH, diabetes mellitus, GERD with a history of chronic neck, right shoulder and right elbow pain, as well as, recurrent right carpal tunnel syndrome (CTS) and clinical left CTS.

\_\_\_ for status post right shoulder rotator cuff repair/right shoulder arthroscopic assisted subacromial decompression follow up reports dated 2/21/02 and 3/21/02.

An occupational therapy evaluation was performed on 3/13/02 from \_\_\_ with program documents thru 6/19/02, and accompanying re-evaluation reports included, dated 4/30/02, 5/29/02, 9/10/02 (post injection evaluation) and 10/21/02. These did not demonstrate that significant functional improvement was being made.

Daily treatment log reports dated 6/14/02 thru 5/27/03 were also included from \_\_\_, which concluded with "they did not have anything else to offer to this patient."

Operative report of injections from \_\_\_ dated 8/05/02 and 9/09/02 stating patients chronic problems as long term with a history of chronic neck, right shoulder and right elbow pain, as well as, recurrent right CTS and clinical left CTS. Both reports denoted claimant tolerated procedure well with 1 month follow up scheduled.

Pain management referral evaluation and assorted follow up reports dated from 3/05/02 thru 10/28/03 by \_\_\_, demonstrate continual problems with only temporary pain relief from injection therapy and post of therapy.

The last update, per TWCC-73 dated 1/07/04, reports the claimant currently not working and awaits possible right CTS surgery.

### **Requested Service(s)**

The medical necessity of the outpatient services for dates of service (DOS) 3/12/03 thru 3/28/03; myofascial release, ultrasound therapy, physical medical treatment – 1 area, electrodes per pair-holder, established office visits / evaluation.

## **Decision**

I agree with the insurance carrier that myofascial release, ultrasound therapy, physical medical treatment – 1 area, electrodes per pairholder, established office visit / other, outpatient visit / evaluation were not medically necessary for DOS 3/12/03 thru 3/28/03, with the exception of established office visit / other, outpatient visit / evaluation on 3/24/03.

## **Rationale/Basis for Decision**

After a through review of documentation supplied by the provider, I did not find enough evidence that would support the use of these services, especially at this point in time. Granted, it is customary practice to utilize some form of active therapy, post injection, to monitor and expedite improvement. However, the types of disputed therapies involved in these dates of service had shown no lasting results from previous trials. Pain was relieved by injection, so modalities were not necessary for pain relief. No apparent swelling was documented, so ultrasound was questionable. One could argue that it helped with the effectiveness of the injections however, this is not readily demonstrated and past trials were evident of its failure.

Myofascial release would also not be necessary, if in fact, the claimant was referred to active type therapy. There is no referenced guides that I know of that would support this type of continued care, especially when numerous scheduled injections with post injection therapy throughout 2002 did not demonstrate significant lasting improvement, only some temporary pain relief. To rationalize that further injections compounded by even more conservative therapy would be of great benefit, did not appear appropriate during 2003 and the final results reinforced this. There were no vast differences in range of motion improvements to speak of and the claimant apparently remained in a functionally limited state despite the repeated use of injections and therapy. This apparent lack of improvement, does not demonstrate that use of these therapies had any more benefit over that of self administered pain relieving techniques and an HEP to maintain current status, especially since only temporary pain relief was the expected outcome, until other medical management decisions could be made.

***Concerning Code 99213;*** there is no reason for this high level of service on a regular basis for this established patient that was involved in post injection occupational therapy, in connection with repetitive treatment over a 2 year period. An office visit, once per month, for follow up would be reasonable, especially since the patient was referred for care through \_\_\_ and the claimant was apparently receiving osteopathic manipulations delivered by this doctor. Furthermore, this type of treatment did not prove to be effective throughout the past years of trial and its use for pain relief is not supported in the documentation. It is fair to say that the temporary bouts of pain relief were basically generated in the form of injections, per documentation for review. It is also apparent that this claimant was prescribed medications throughout this post injection period and its use has not lessened in connection with these other conservative care measures, for the most part. These statements are supported by the TWCC Spine & Extremity Guideline<sup>1</sup>, used as a reference.

***Concerning Electrodes:*** I have no reference on the use or benefit of any type of durable medical equipment in the form of TENS or neuromuscular stimulation for this claimant throughout this documentation. Without this documentation and in light of continuous medication usage, use of this modality cannot be considered as medically necessary.

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<sup>1</sup> Even though the TWCC Spine & Extremity Treatment Guideline has been abolished, it still remains a reliable reference source to provide guidance, regarding the necessity of treatment.