

MDR Tracking Number: M5-02-2138-01

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 office visits were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that office visit fees were the only fees involved in the medical dispute to be resolved. As the treatment was not found to be medically necessary, reimbursement for dates of service from 1/29/01 to 12/3/01 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 12th day of March 2003.

Noel L. Beavers  
Medical Dispute Resolution Officer  
Medical Review Division

NLB/nlb

March 8, 2003

Rosalinda Lopez  
Texas Workers' Compensation Commission  
Medical Dispute Resolution  
4000 South IH-35, MS 48  
Austin, TX 78704-7491

Re: Medical Dispute Resolution  
MDR #: M5.02.2138.01  
IRO Certificate No.: 4326

Dear Ms. Lopez:

\_\_\_ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, \_\_\_ reviewed relevant medical records, any documents provided by the parties

referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is Board Certified in Physical Medicine and Rehabilitation.

Clinical History:

This 34-year-old female claimant sustained musculo-ligamentous injuries to her neck, low back, and left shoulder with myofascial pain syndrome, in a slip-and-fall accident on \_\_\_\_\_. An exam by the treating physician on 10/20/92, revealed only musculoskeletal strain. The physical exam was normal with normal reflexes in the biceps and triceps, with normal strength in the upper and lower extremities, and virtually normal range of motion in the cervical and lumbar spine. The progression of pain was treated completely appropriately at that time. There was no evidence of nerve damage or motor or sensory deficit almost one year after the original injury.

Disputed Services:

Office visits during the period of 01/29/01 through 12/03/01.

Decision:

The reviewer agrees with the determination of the insurance carrier. The reviewer is of the opinion that the office visits from 01/29/01 through 12/03/01, were not medically necessary in this case.

Rationale for Decision:

It should be noted that the treating physician's examination of 10/20/92, was done almost a year after the injury, and still the impression was only musculoskeletal strain. The physical exam revealed normal reflexes in the biceps and triceps, with normal strength in the upper and lower extremities, and virtually normal range of motion in the cervical and lumbar spine.

No documentation was found as to how the patient went from a normal physical exam to eventually having spinal stenosis for which she had surgery on 02/24/97. There was no report, other than by verbatim, of the MRI of her cervical spine. The records commented on the MRI, that she had a herniated disc, asymmetric, and that she had spinal stenosis, thus the surgical procedure, but this report was not provided in the records. However, even if it was, it is somewhat irrelevant. This would have been taken quite a few years after her original injury, after which it was clearly indicated

that there was no evidence of nerve damage, motor or sensory deficit.

The reviewer noted that the treating physician's letter of 08/28/00, giving the patient's history, contains numerous, significant discrepancies from the history given originally at the onset of the patient's treatment for her injury in \_\_\_\_\_. No documentation was presented to explain what occurred between the time of the injury in \_\_\_\_\_, to the period in question of 01/01 through 12/01, that may have drastically changed the patient's symptoms, thus requiring continued office visits during the period in question. Also, no documentation was presented to warrant the medical necessity of the office visits in question.

I am the Secretary and General Counsel of \_\_\_\_\_ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,