MDR Tracking Number: M5-02-2630-01

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 office visits rendered were not medically necessary.

Based on review of the disputed issues within the request, the Division has determined that office visits fees were the only fees involved in the medical dispute to be resolved. As the treatment, office visits, were not found to be medically necessary, reimbursement for dates of service from 5/21/01 through 11/5/01 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 8th day of October 2002.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

September 24, 2002

Re: Medical Dispute Resolution
MDR #: M5-02-2630-01
IRO Certificate No.: IRO 5055

Dear

___ 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 a doctor of Chiropractic Medicine.

The physician reviewer AGREES with the determination of the insurance carrier in this case. The reviewer is of the opinion that treatment on 05.21.01, 06.19.01, 07.02.01, 09.24.01, 10.22.01, and 11.05.01 WAS NOT MEDICALLY NECESSARY.

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

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted.

Sincerely,

MEDICAL CASE REVIEW

This is for ___. I have reviewed the medical information forwarded to me concerning MDR #M5-02-2630-01, in the area of Chiropractic. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Medical Dispute Resolution Request/Response.
2. Table of Disputed Services.
3. Explanation of Benefits from the insurance carrier, denying payment, 7 pages.
4. Insurance carrier physician's report and peer review report from ___, 6 pages.
5. Treating doctor's clinical summary notes, evaluation and re-evaluation summary notes, daily progress and procedure notes; muscle testing reports; MRI report; radiographic report; and consultation report-- total 153 pages.

B. BRIEF CLINICAL HISTORY:

The records indicate the patient was injured on the job while lifting on ___. The patient received chiropractic care and therapy and was referred for a consultation with ___. ___ evaluated the patient on 12/01/99 and prescribed Celebrex and Skelaxin. An MRI was performed on 12/21/99 which revealed an L4-L5 disk herniation. Treatment had been ongoing since the injury, with the last patient visit, per patient's review, being 11/05/01.

C. DISPUTED SERVICES:

Treatment dates 5/21/01, 6/19/01, 7/02/01, 9/24/01, 10/22/01, 11/05/01.

D. DECISION:

I AGREE WITH THE DETERMINATION OF THE INSURANCE CARRIER IN THIS CASE.

E. RATIONALE OR BASIS FOR DECISION:

The records indicate this patient has had ongoing care for an extended period of time since the initial date of injury on ___. The office notes provided by ___, the treating doctor, dated 12/18/00, state this patient's treatment frequency was to be modified to two times a month. That continued up to and included 11/05/01. In reviewing the records supplied regarding the dates of disputed services, in each case except on 9/24/01, the patient indicated his overall pain at a level of 1 on a scale from 0 to 10, with 0 being no pain and 10 being the worst possible pain. On 9/24/01, the patient indicated a pain level of 2.

Based upon these records, it is my opinion the patient was not being treated on a p.r.n. basis but on a twice-per-month basis regardless of his condition at the time of his treatment appointment scheduled time. The Texas Worker's Compensation *Treatment Guidelines* allow for lifetime medical benefits as long as the treatment is reasonable, related, and medically necessary for the patient. It is my professional opinion that it is not medically necessary for the patient to be seen on a schedule of twice per month, almost two years after the original date of injury. In addition, for the patient to come in for treatment with essentially minimal to no pain, as per the pain scale of 1, I would classify this as maintenance care and not medically necessary under the TWCC *Guidelines* that were in effect at that time. It is further my opinion, based upon the MRI findings, that this patient will probably need some type of treatment for an extended period of time on a p.r.n. basis and when he has an increase in his symptomatology.

F. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

Date: 19 September 2002