

MDR Tracking Number: M5-02-3080-01

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 and physical therapy was 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 and physical therapy 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 1/18/02 to 4/12/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 14th day of February 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

NOTICE OF INDEPENDENT REVIEW DECISION

January 29, 2003

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

RE: MDR Tracking #: M5-02-3080-01
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 44 year old female sustained a work-related injury on ___ when she injured her lower back while driving a school bus. A lumbar MRI performed on 11/27/01 revealed a L4-5 right posterolateral annular tear and mild foraminal narrowing. It also revealed a L5-S1 posterior disc bulge and mild foraminal narrowing. A functional capacity evaluation (FCE) was performed on 11/02/01, and indicated that the patient was functioning at a light physical demand level. Ranges of motion performed on 11/02/01 of lumbar spine were severely restricted. Electrodiagnostic evaluation of the lower extremity on 02/06/02 indicated a mild to moderate left-sided L5 radiculopathy. A followup FCE was performed on 02/15/02, which indicated a 3% whole person improvement due to ranges of motion increases. Also indicated during this FCE on 02/15/02 were decreases in static lifting for lower extremity tasks. The physical demand level for 02/15/02 was listed as light, which is the same as that listed on the previous FCE. Ranges of motion demonstrated during the FCE on 02/15/02 revealed dramatic improvement with most values approaching normal. A third FCE was performed on 04/18/02. The physical demand level was indicated as light to medium. Additionally, ranges of motion were at or near normal values as demonstrated during the FCE. A designated doctor examination was performed on 07/16/02, which indicated that the patient was at maximum medical improvement and was assigned a 5% whole person impairment due to the low back injury of 03/29/01.

Requested Service(s)

Chiropractic care provided from 01/18/02 through 04/12/02.

Decision

It is determined that the chiropractic care provided from 01/18/02 through 04/12/02 was not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The true nature, location and duration of each treatment as well as the objective response to said treatment are insufficiently documented to determine their medical necessity. The daily notes are lacking substantial information to determine where on the patient the treatment was performed, how long the treatments lasted (particularly necessary for therapeutic exercises) and exactly what modalities were used. Given the fact that the patient was 8 to 9 months post injury, it was mandatory that the patient's care be sufficiently documented in order to substantiate medical necessary. Therefore, the chiropractic care provided from 01/18/02 through 04/12/02 is not substantiated as medically necessary.

Sincerely,