

MDR Tracking Number: M5-03-1391-01

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, 2003 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 and physical therapy 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 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 8/19/02 to 9/24/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 16th day of May 2003.

Noel L. Beavers
Medical Dispute Resolution Officer
Medical Review Division
NLB/nlb

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

May 9, 2003

Re: IRO Case # M5-03-1391-01

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic who is licensed by the State of Texas. He or she has signed a certification statement attesting 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 referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient injured her lower back on ___ while lifting several eight pound boxes. She sought chiropractic treatment 10/3/00.

Requested Service

Office visits, physical therapy 8/19/02 – 9/24/02

Decision

I agree with the carrier's decision to deny the requested treatment.

Rationale

The patient had extensive conservative treatment prior to the disputed dates of service, and all the documentation provided for this review points to the fact that the patient had recovered from the injury sustained on ___ and all symptoms had resolved before the disputed dates. In a review dated 10/10/01, a doctor reports, "this patient has recovered completely from the injury sustained," and that "she will have no permanent disability." One doctor placed the patient on MMI on 2/1/02 with a 0% Whole Body Impairment Rating, and another doctor placed the patient on MMI on 8/1/01 with a 7% Whole Body Impairment Rating.

The documentation presented suggests that the patient sustained a sprain/strain to the lumbar spine that was superimposed on preexisting degenerative changes. This condition should have responded and resolved within 8-12 weeks of conservative treatment. It is difficult to identify the causal relationship between the patient's injury and the treatment provided.

After the MMI date of 2/1/01 was reached all further treatment must be reasonable and effective in relieving symptoms and restoring function. The documentation presented failed to show how the disputed services were necessary. In this case, it appears from the records that the treatment was totally unnecessary, far too intensive, and without documentation to support treatment.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

Sincerely,