

MDR Tracking Number: M5-03-2453-01

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 6/2/03.

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/consultations, NCV study, H or F reflex study, temperature gradient study, electrodes, analysis of information, myofascial release, hot/cold pack, electrical stimulation, ultrasound, spinal and pelvic echography, therapeutic procedures/activities and physical performance tests 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 fees were the only fees involved in the medical dispute to be resolved. As the treatment office visits/consultations, NCV study, H or F reflex study, temperature gradient study, electrodes, analysis of information, myofascial release, hot/cold pack, electrical stimulation, ultrasound, spinal and pelvic echography, therapeutic procedures/activities and physical performance tests were not found to be medically necessary, reimbursement for dates of service from 10/14/02 to 1/15/03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 20th day of, August 2003.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO decision

NOTICE OF INDEPENDENT REVIEW DECISION

August 13, 2003

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

RE: Injured Worker:
MDR Tracking #: M5-03-2453-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) 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 TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF 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. TMF's 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 TMF 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 patient sustained a low back injury on . while bending over and lifting a 60-pound bag. He went to physical therapy and was placed on anti-inflammatory and muscle relaxant medications. The patient reported no relief and complained of worsening symptoms. He then saw a chiropractor for treatment and therapy.

Requested Service(s)

Office consultations, NCV study, H or F reflex study, temperature gradient study, electrodes, analysis of information, myofascial release, hot/cold pack, electrical stimulation, office visits, ultrasound, spinal and pelvic echography, therapeutic procedures, therapeutic activities, and physical performance tests from 10/14/02 through 01/15/03

Decision

It is determined that the office consultations, NCV study, H or F reflex study, temperature gradient study, electrodes, analysis of information, myofascial release, hot/cold pack, electrical stimulation, office visits, ultrasound, spinal and pelvic echography, therapeutic procedures, therapeutic activities, and physical performance tests from 10/14/02 through 01/15/03 was not medically necessary to treat this patient's condition

Rationale/Basis for Decision

The treatments rendered from 10/14/02 through 01/15/03 were not medically necessary due to lack of rational and qualitative and quantitative assessment outcomes in establishing support for his specific chiropractic applications. The diagnostic pelvis ultrasound and temperature gradient study were not supported by appropriate rationale its application to this specific diagnosis. The results are not discussed in the recommendations in supporting, developing, or changing treatment protocol or applications. These studies do

not assess or distinguish the patient's condition versus injury for proper evaluation and then develop appropriate recommendations.

A nerve conduction velocity (NCV) test is not the preferred study for radiculopathy. In this case, there was no exam, case history, or objective findings with any doctor that would have supported a NCV or electromyography (EMG). No rationale was stated to support these studies.

The initial four weeks leading up to the designated doctor exam (DDE) is medically necessary and supported by the doctor's notes to render chiropractic treatment protocols. At the four week mark, a physical re-assessment should have been performed with progressive treatment applications.

The functional capacity evaluation (FCE) from 12/12/02 and 01/08/03 were not performed with the patient's job description, capacity, or recommendations identified. There was no treatment plan formulated supported by the quantitative data. Considering this, the FCEs were not medically necessary.

The follow references were utilized in this decision:

1) *Unremitting low back pain, North American Spine Society (phase III) clinical guidelines for multi-disciplinary spine care specialists.* North American Spine Society; 2000, 96 p.

2) *American College of Radiologists' Appropriate Criteria for Acute Low Back Pain;* Journal of Radiology, 2000.

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment