

**THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

SOAH DOCKET NO. 453-04-1959.M5

MDR Tracking Number: M5-04-0012-01

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 August 29, 2003.

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 therapeutic exercises, myofascial release, joint mobilization, physical medicine treatment, electrical stimulation and office consultation 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 therapeutic exercises, myofascial release, joint mobilization, physical medicine treatment, electrical stimulation and office consultation were not found to be medically necessary, reimbursement for dates of service from 9/6/02 through 9/30/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 4th day of November 2003.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division
MQO/mqo

October 27, 2003

MDR Tracking #: M5-04-0012-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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 care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Chiropractic. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating

that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

CLINICAL HISTORY

This patient was referred to the requestor by ___ for an exacerbation of his low back condition that caused pain into the right leg and into the lateral part of his right foot. The requestor evaluated the patient and put in motion a plan to increase his strength and decrease the lumbar muscle spasm, which the letter of explanation from the requestor claims did happen. ___ states that upon his re-evaluation, the ROM and strength had returned and spasms in the low back had decreased significantly. The carrier's reviewer, ___ denied the medical necessity of the care due to the fact that there was a lack of documentation to prove medical necessity, especially in light of the fact that a previous FCE was performed that demonstrated a full ability to perform the duties of his job.

DISPUTED SERVICES

Under dispute is the medical necessity of therapeutic procedures, myofascial release, joint mobilization, physical medicine treatment, electrical stimulation and office consultation.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

There was no documentation in this file that would indicate or prove the medical necessity of the treatment rendered. While a full FCE is not necessarily required for each exacerbation, one would expect that a requestor would document the reasoning for the care being rendered, its outcome and the prognosis in a SOAP note format. This is not done in this file and there is no way to look at the records presented and presume that the care was reasonably effective in treating this patient's injury.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy

As an officer of ___ ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,