

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

SOAH DOCKET NO: 453-04-3737.M5

MDR Tracking Number: M5-04-0317-01

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 September 3, 2004.

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 service 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 fees were the only fees involved in the medical dispute to be resolved. As the treatment listed above was not found to be medically necessary, reimbursement for dates of service from 09-03-02 to 11-20-02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 4th day of February 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division
PR/pr

January 30, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-0317-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or

providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a female who sustained a work related injury on ____. A lumbar ultrasound dated 4/12/02 indicated mild bilateral facet area inflammation at L1-L3. Treatment for this patient's condition has included physical therapy, electrical muscle stimulation and therapeutic procedures.

Requested Services

Office visits and physical therapy services from 9/3/02 through 6/25/03.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is upheld.

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a female who sustained a work related injury to her back on ____. The ___ chiropractor reviewer also noted that an ultrasound dated 4/12/02 indicated mild bilateral facet area inflammation at the L1-L3 levels. The ___ chiropractor reviewer further noted that treatment for this patient's condition has included physical therapy, electrical stimulation and therapeutic procedures. The ___ chiropractor reviewer indicated that the patient had been treated from 9/6/02 through 10/30/02 without any documented complaints of pain. The ___ chiropractor reviewer noted that on 11/6/02 the documentation indicated that the patient complained of pain in her neck and shoulder area, without an explanation of why. The ___ chiropractor reviewer indicated that on 12/6/02 the patient complained of pain rating a 9/10, without a documented explanation of the increase. The ___ chiropractor reviewer explained that the records provided do not support the need for continued care without documentation of objective findings supporting the length of care. The ___ chiropractor reviewer also explained that the patient's progress was documented as improving or doing well with a pain rating of 10/10. The ___ chiropractor reviewer further explained that the documentation provided did not demonstrate that the treatment provided was promoting a cure. Therefore, the ___ chiropractor consultant concluded that the office visits and physical therapy services from 9/3/02 through 6/25/03 were not medically necessary to treat this patient's condition.

Sincerely,