

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

SOAH DOCKET NO. 453-04-4457.M5

MDR Tracking Number: M5-04-0341-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 10-2-03.

The Medical Review 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 w/manipulations, therapeutic exercises, therapeutic activities, whirlpool, and aquatic exercises were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

The disputed dates of service 9-23-02 through 9-27-02 are untimely and ineligible for review per TWCC Rule 133.307 (d)(1) which states that a request for medical dispute resolution shall be considered timely if it is received by the Commission no later than one year after the dates of service in dispute. The Commission received the medical dispute on 10-2-03.

Based on review of the disputed issues within the request, the Medical Review Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service from 10-4-02 to 12-12-02 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 23rd day of February 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

DZT/dzt

January 8, 2004

**NOTICE OF INDEPENDENT REVIEW DECISION
Corrected Letter**

**RE: MDR Tracking #: M5-04-0341-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
----- Case #:**

----- 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 29 year-old female who sustained a work related injury on ----- . The patient reported that while at work she sustained a repetitive motion injury to her neck, back and both legs. The patient underwent X-Rays that were reported to be normal. An MRI of the cervical spine dated 6/21/02 revealed a disc protrusion at C5-C6 with mild thecal impingement without foraminal encroachment. An MRI of the right and left wrist dated 6/24/02 indicated fluid over the ulnar styloid of the right wrist and increased signal intensity in the volar aspect of the distal radial carpal joint. Diagnoses for this patient's condition have included cervicgia with radiculopathy secondary to a herniated nucleus propulsus at the C5-C6 level, and probable cervical facet joint arthropathy. The patient has been treated with physical therapy, medication, chiropractic adjustments and cervical epidural injections.

Requested Services

Office visit with manipulation, therapeutic exercises/activities, whirlpool, physical medicine treatment and aquatic therapy/exercises from 10/4/02 and 12/12/02.

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 29 year-old female who sustained a work related injury to her neck, back and both legs on ----- . The ----- chiropractor reviewer also noted that the diagnoses for this patient have included cervicgia with radiculopathy secondary to a herniated nucleus propulsus at the C5-C6 level, and probable

cervical facet joint arthropathy. The ----- chiropractor reviewer further noted that the patient has been treated with physical therapy, medication, chiropractic adjustments and cervical epidural injections. The ----- chiropractor reviewer explained that the documentation provided does not demonstrate that the exacerbation was related to the original work related injury. The ----- chiropractor reviewer further explained that the documentation provided does not show medical necessity for treatment rendered. Therefore, the ----- chiropractor consultant concluded that the office visit with manipulation, therapeutic exercises/activities, whirlpool, physical medicine treatment and aquatic therapy/exercises from 10/4/02 and 12/12/02 were not medically necessary to treat this patient's condition.

Sincerely,
