

MDR Tracking Number: M5-04-0586-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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. This dispute was received on 9-30-03.

The IRO reviewed massage and joint mobilization on 10-23-02 and 10-28-02.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

The disputed dates of service 9-9-02 through 9-26-02 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 9-30-03.

Based on review of the disputed issues within the request, the Medical Review Division has determined that only medical necessity fees were involved in the medical dispute to be resolved. As the massage and joint mobilization were not found to be medically necessary, reimbursement for dates of service 10-23-02 and 10-28-02 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 20<sup>th</sup> day of February 2004.

Dee Z. Torres  
Medical Dispute Resolution Officer  
Medical Review Division

January 23, 2004

#### **NOTICE OF INDEPENDENT REVIEW DECISION**

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\_\_\_ 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 31 year-old female who sustained a work-related injury on \_\_\_. The patient reported that while at work she was involved in an altercation with a juvenile when she was thrown back falling onto some furniture. The patient underwent a MRI on 8/2/02 that revealed no evidence of disc bulging or disc herniation. The diagnoses for this patient have included lumbosacral sprain/strain, lumbar radiculitis, thoracic sprain/strain, sacroiliac joint dysfunction, lumbar articular dysfunction, and myositis/myalgia. Treatment for this patient's condition has included oral medications, joint manipulation, ultrasound, massage therapy, sacroiliac joint injections, and electrical stimulation.

### Requested Services

Joint mobilization, therapeutic procedures (massage) from 10/23/02 through 10/28/02

### 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 31 year-old female who sustained a work related injury to her back on \_\_\_. The \_\_\_ chiropractor reviewer also noted that treatment for this patient's condition has included oral medications, joint manipulation, ultrasound, massage therapy, sacroiliac joint injections, electrical stimulation and therapeutic procedures. The \_\_\_ chiropractor reviewer indicated that the patient had been treated for 4 ½ months three times a week. The \_\_\_ chiropractor reviewer also indicated that on 9/27/02, it was recommended that the patient undergo epidural steroid injections and to discontinue ongoing passive care. The \_\_\_ chiropractor reviewer explained that the ongoing treatment was not leading to a resolution of the patient's condition or a real change in her work capabilities. The \_\_\_ chiropractor reviewer also explained that the SOAP notes provided indicated that the patient reported pain levels as staying the same, slightly worse, or some improvement at each visit. The \_\_\_ chiropractor reviewer further explained that the records did not indicate where the patient's pain was. Therefore, the \_\_\_ chiropractor consultant concluded that the Joint mobilization, therapeutic procedures (massage) from 10/23/02 through 10/28/02 were not medically necessary to treat this patient's condition.

Sincerely,