

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

SOAH DOCKET NO. 453-04-2849.M5

MDR Tracking Number: M5-04-0608-01

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 October 28, 2003.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

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

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The chiropractic services including therapeutic activities, ADL training, therapeutic exercise and aquatic therapy were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

This findings and decision is hereby issued this 9th day of January 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 04/28/03 through 05/21/03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 9th day of January 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division
PR/pr

**NOTICE OF INDEPENDENT REVIEW DETERMINATION
REVISED 1/8/04**

MDR Tracking Number: M5-04-0608-01

December 17, 2003

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ____, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY

Available information suggests that this patient reports injury to his back while performing work related activity on ____. The patient presents initially to ___ where he is treated and released for an uncomplicated lumbar strain. He then presents to his chiropractor, ____, and is diagnosed with a lumbar sprain/strain and disc disorder. Multiple units of physical therapy are provided. Lumbar MRI is performed 3/28/03 suggesting multilevel disc bulging with HNP, L3/4 annular tear and facet arthrosis. The patient is referred for orthopedic evaluation with ____, on 4/3/03 where he is diagnosed with lumbar disc disease, radiculitis and myalgia. Neurodiagnostic studies, myelogram and ESI's are recommended if improvement is not experienced with conservative care. The patient appears to be put in a reconditioning program including multiple modalities, ADL training, and therapeutic exercises. Follow-up medical evaluation is made on 5/21/03 with ____, suggesting that the patient is still experiencing radicular pain consistent with lumbar disc derangement and facet inflammation. The patient is given

pain medications and neurodiagnostic evaluation is also recommended. Intramuscular and ESI injections are also recommended if patient fails to improve. Functional capacity evaluation is performed confirming de-conditioning and functional deficits related to lumbar spine disorder.

REQUESTED SERVICE (S)

Determine medical necessity for chiropractic services including therapeutic activities, ADL training, therapeutic exercise and aquatic therapy for dates of service 4/28/03 through 5/21/03.

DECISION

Therapeutic applications, including therapeutic activities, therapeutic exercise, ADL training and aquatic therapy do appear reasonable and medically necessary as applied for the period of 4/28/03 to 5/21/03.

RATIONALE/BASIS FOR DECISION

1. Hurwitz EL, et al. The effectiveness of physical modalities among patients with low back pain randomized to chiropractic care: Findings from the UCLA Low Back Pain Study. *J Manipulative Physiol Ther* 2002; 25(1): 10-20.
2. Bigos S., et al., AHCPR, Clinical Practice Guideline, Publication No. 95-0643, Public Health Service, December 1994.
3. Harris GR, Susman JL: "Managing musculoskeletal complaints with rehabilitation therapy" *Journal of Family Practice*, Dec. 2002.
4. Morton JE. Manipulation in the treatment of acute low back pain. *J Man Manip Ther* 1999; 7(4): 182-189.
5. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Mercy Center Consensus Conference, Aspen Publishers, 1992.
6. Philadelphia Panel Evidence-Based Clinical Practice Guidelines on Selected Rehabilitation Physical Therapy, Volume 81, Number 10, October 2001.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review.

This review and its findings are based solely on submitted materials. No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned claimant. These opinions rendered do not constitute a per se recommendation for specific claims or administrative functions to be made or enforced.