

MDR Tracking Number: M5-04-1091-01

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 December 15, 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, office evaluation (15 min), therapeutic activities, and MT-Functional capacity evaluation-muscle testing 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 treatment listed above were not found to be medically necessary, reimbursement for dates of service from 03-24-03 to 04-02-03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 27th day of February 2004.

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

February 24, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-1091-01

___ 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 ____. The patient reported that while at work she slipped on a wet floor and fell injuring her neck, thoracic and lumbar spine, shoulder, elbow and hip. On 2/10/03 the patient underwent an EMG/NCV of the upper extremities that reported no electrophysiological evidence of cervical radiculopathy, brachial plexopathy, or distal mononeuropathy. The patient underwent a MRI of the cervical spine on 1/30/03 that indicated straightening of the usual or expected lordosis, a 3mm unconcertebral joint marginal bony osteophytes at the C5-6 and C6-7 level. A MRI of the lumbar spine dated 3/30/03 indicated posterior central annular tear at the L4-5 level and a 2mm symmetrical annular bulge at minimal facet arthrosis. The diagnoses for this patient have included lumbar disc disorder, cervical sprain/strain, thoracic pain, and shoulder sprain/strain. Treatment for this patient's diagnoses has included physical therapy, TENS unit, epidural steroid injections, therapeutic exercises, and therapeutic activities.

Requested Services

Therapeutic exercises, office evaluation (15 min), therapeutic activities, and MT-Functional capacity evaluation – muscle testing from 3/24/03 through 4/2/03.

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 neck, thoracic and lumbar spine, elbow and hip on ____. The ___ chiropractor also noted that the diagnoses for this patient have included lumbar disc disorder, cervical sprain/strain, thoracic pain, and shoulder sprain/strain. The ___ chiropractor reviewer further noted that treatment for this patient's condition has included physical therapy, TENS unit, epidural steroid injections, therapeutic exercises, and therapeutic activities. The ___ chiropractor reviewer explained that the patient showed no improvement with the treatment rendered from 2/24/03 through 4/2/03. The ___ chiropractor reviewer indicated that although the patient showed some objective improvement in her neck and shoulder areas by 3/6/03, the patient failed to demonstrate any improvement in her low back even after an epidural steroid injection performed on 3/25/03. The ___ chiropractor reviewer noted that after 2 ½ months of treatment, this patient failed to show improvement in her pain pattern and had not returned to work. Therefore, the ___ chiropractor consultant concluded that the therapeutic exercises, office evaluation (15 min), therapeutic activities, and MT-Functional capacity evaluation – muscle testing from 3/24/03 through 4/2/03 were not medically necessary to treat this patient's condition.

Sincerely,