

MDR Tracking Number: M5-04-1141-01

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 19, 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 physical therapy treatments, office visits, unlisted modality, hot/cold packs, and electrical stimulation 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 12-27-02 to 09-26-03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 29th day of March 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

PR/pr

March 24, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-1141-01

___ 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 30 year-old male who sustained a work related injury on ____. The patient reported that while at work he injured his back. X-Rays of the lumbar spine dated 3/7/00 were reported as showing a left lumbar convexity, apexing at L2-L3, with mild lumbar hypolorodosis and early signs of spondylosis at L1 through L3. A nerve conduction study of the lower extremities dated 6/6/00 indicated a left tibial neuropathy. On 6/23/00 the patient underwent an MRI of the lumbar spine that was reported to have shown upper and mid-lumbar hypolorodosis. The diagnoses for this patient have included spondylosis of the lumbar spine, with muscle spasm, lumbosacral neuritis, lumbago, intervertebral disc prolapse, and radiculitis. Treatment for this patient's condition has included joint mobilization, myofascial release, neuromuscular reeducation, and therapeutic exercises.

Requested Services

Physical therapy treatments, office visits, unlisted modality, hot/cold packs, electrical stimulation from 12/27/02 through 9/26/03.

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 30 year-old male who sustained a work related injury to his back on ____. The ___ chiropractor reviewer also noted that the diagnoses for this patient have included spondylosis of the lumbar spine, with muscle spasm, lumbosacral neuritis, lumbago, intervertebral disc prolapse, and radiculitis. The ___ chiropractor reviewer indicated that the care in question is ___ years after the original injury. The ___ chiropractor reviewer noted that the patient was returned to work with an 8% impairment rating on 1/29/01. However, the ___ chiropractor reviewer explained that the documentation provided did not show that the patient's condition was aggravated by his work duties. The ___ chiropractor reviewer also explained that this patient had an underlying pre-existing curvature of the spine and hypolorodosis that may be underlying cause of his current back pain. The ___ chiropractor reviewer further explained that the treatment rendered to this patient did not offer significant relief or lead to a return to work as he had already returned to work. The ___ chiropractor reviewer indicated that the patient does not report a significant increase in pain noted from any activity he does. The ___ chiropractor reviewer noted that the reported pain is consistently in the 2-4/10 range when he presented for care. The ___ chiropractor reviewer explained that due to the lack of present neurologic signs or radicular pain, the treatment rendered to this patient was not medically necessary. Therefore, the ___ chiropractor consultant concluded that the physical therapy treatments, office visits, unlisted modality, hot/cold packs, electrical stimulation from 12/27/02 through 9/26/03 were not medically necessary to treat this patient's condition.

Sincerely,