

MDR Tracking Number: M5-04-1438-01

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 1-22-04.

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, therapeutic procedures, joint mobilization, myofascial release, ultrasound, aquatic therapy, and electrical stimulation from 6/18/03 through 7/09/03 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 Medical Review Division has determined that medical necessity 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 6/18/03 through 7/09/03 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 12th day of May 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division

RLC/rlc

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

May 2, 2004

Re: IRO Case # M5-04-1438

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule 133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate.

For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic, who is licensed by the State of Texas, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

Medical Information Reviewed

1. Table of Disputed Services 6/18/03 – 7/9/03
2. Explanation of benefits
3. Response to IRO request for records 3/9/04
4. TWCC first report of injury
5. Initial D.C. report 3/4/03
6. D.C. treatment notes
7. Report 3/13/03
8. Work hardening notes
9. Subsequent medical reports from D.C.
10. Report 8/20/03
11. TWCC 69 reports
12. Computerized spinal ROM exam 8/12/03
13. Operative report 8/12/03
14. Reports from physician to whom patient was referred
15. NCS report 5/22/03
16. RME report 5/17/03
17. Exhibit D – containing medical records, clinical notes, diagnostic test results, treatment plans and documents

History

The patient injured his lower back on ___ when he was loading luggage and felt pain. He went to a clinic, and then to the treating D.C. He has been evaluated with MRI and electrodiagnostic studies. He has been treated with chiropractic treatment, medication, and injections

Requested Service(s)

Ovs, electrical stimulation, joint mobilization, myofascial release, ultrasound, aquatic therapy, therapeutic procedures 6/18/03-7/9/03

Decision

I agree with the carrier's decision to deny the requested services.

Rationale

The patient had an adequate 3-½ month-trial of chiropractic treatment prior to the dates in dispute that failed to relieve his symptoms or to improve function. A 5/17/03 RME report recommended a two-week work conditioning program and a return to work without restrictions. Instead, the failed chiropractic treatment was continued another two months with poor results, and the patient remaining off work. The patient's condition failed to change despite intensive treatment from the D.C. After three months of failed treatment, the patient's VAS was still 9 or 10/10 at times. On 6/20/03 the patient stated that his pain, at present, was the "worst imaginable," and that his sex life was "nearly absent because of pain," and that he needed a special time to talk with the doctor. This was after about 3 ½ months of treatment from the D.C.

On 5/13/03 a consulting physician recommended starting lumbar facet and left sacroiliac joint diagnostic blocks to alleviate the patient's pain and increase his functional status, yet the D.C. continued his failed treatment and did not follow through on the recommendations until two months later. The failure of conservative therapy modalities does not establish a medical rationale for additional non-effective therapy. The services in dispute were not appropriate. The records provided for review did not show that treatment was reasonable and effective in relieving symptoms or improving function. A lumbar sprain/strain should resolve with appropriate care in four to six weeks. After four to six weeks of treatment without success, the patient should have been referred to a spine surgeon for further evaluation.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.