

MDR Tracking Number: M5-04-1575-01

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 2-2-04.

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 therapeutic exercises, therapeutic activities, and neuromuscular re-education from 4/7/03 to 5/23/03 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 4/7/03 to 5/23/03 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 21st day of April 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division
RLC/rlc

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

April 9, 2004

Re: IRO Case # M5-04-1575

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:

History

The patient injured her lower back in ___ when she slipped and fell. EMG and MRI evaluation have been obtained. The patient has been treated with physical therapy, chiropractic treatment, medication and epidural steroid injections.

Requested Service(s)

Therapeutic exercises, therapeutic activities, neuromuscular reeducation 4/7/03-5/23/03

Decision

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

Rationale

The patient received a fair trial of intensive chiropractic treatment prior to the dates in dispute without documented relief of symptoms or improved function. The documentation provided for this review is poor, and lacks specific quantitative findings to support treatment for the dates in dispute. The treatment notes are repetitive and lack both objective findings and subjective complaints. Therapeutic notes are non-descriptive, lack a treatment plan, and lack the patient's response to the exercises. The documentation also lacks periodic re-exam reports describing response to treatment, treatment plan and clinical findings to support continued treatment.

In his FCE report dated 4/24/03 the D.C. stated that the patient was functioning at a sedentary physical demand level, with eleven deficits listed. This was some five months after intensive chiropractic treatment, therapeutic exercises and lumbar epidural steroid injections.

The patient was placed at MMI on 1/19/03. After an MMI date is reached, all further treatment should be reasonable and effective in relieving symptoms or improving function.

The documentation provided for this review did not show how the disputed services were necessary.

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