

MDR Tracking Number: M5-04-1685-01

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 February 10, 2004.

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 office visits, electrical stimulation, joint mobilization, myofascial release, ultrasound, aquatic therapy, and therapeutic procedures 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 02-17-03 to 03-19-03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 24<sup>th</sup> day of May 2004.

Patricia Rodriguez  
Medical Dispute Resolution Officer  
Medical Review Division

PR/pr

**IRO Certificate #4599**

**NOTICE OF INDEPENDENT REVIEW DECISION**

May 2, 2004

**Re: IRO Case # M5-04-1685**

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 2/17/03 – 3/19/03
2. Explanation of benefits
3. Review 3/24/03
4. Letter from carrier to IRO 3/24/04
5. Recommendation Review 8/28/03
6. Modality Review 3/11/03
7. MRIs of scrum and coccyx and lumbar spine 12/18/02
8. FCE reports 2/13/03, 3/3/03, 3/21/03
9. Letter of medical necessity 8/9/03
10. Daily work hardening notes from treatment provider
11. MDR request 2/9/04
12. Exercise sheets from treatment provider
13. Report of medical evaluation
14. IR report 4/8/03
15. Fox log reports from treatment provider
16. Treatment notes and records from treating D.C.

#### History

The patient injured his lower back on \_\_\_ when he slipped and fell off a ladder. He began chiropractic treatment on 12/11/02. MRI evaluations of the lumbar spine, sacrum and coccyx were normal.

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 received a very fair trial of chiropractic treatment, including around 29 dates of service prior to the work hardening program. A diagnosed lumbar sprain/strain should resolve within four to eight weeks. Before entering the work hardening program, the patient was capable of handling the medium to heavy work load required for his job. This was established on the initial FCE performed on 2/13/03, prior to the start of the work hardening program. The documentation from the treating D.C. did not show how the work hardening program was necessary, and the records from the work hardening program did not show that the program was beneficial to the patient. In addition, it was not cost effective treatment.

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