MDR Tracking Number: M5-04-1735-01

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 2-13-04.

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, joint mobilization, myofascial release, manual traction, and therapeutic exercises from 3/18/03 through 9/23/03 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 3/18/03 through 9/23/03 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 3rd day of June 2004.

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

May 18, 2004

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

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___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Chiropractic. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

The records presented on this case are treatment records for injuries which are only described as "traumatic work related" injuries to the low back. The impairment rating report by Dr. B, dated June 9, 2003, indicates that the patient was diagnosed with a lumbar disc disorder as well as myospasm and segmental dysfunction. The patient was treated with aggressive care by the treating provider for several months after the injury. The care included active and passive therapies along with chiropractic manipulation. The patient was found at MMI with 5% impairment by the treating doctor. The records presented were extensive and described the care rendered, but no record of MRI/CT or EMG was found in the package presented by the requestor. Records were received from the carrier and requestor documenting the physical medicine. The carrier's EOB's indicate that there was a peer review performed, but it was not included those records.

DISPUTED SERVICES

The carrier has denied the medical necessity of office visits, joint mobilization, myofascial release, manual traction and therapeutic exercises from March 18, 2003 through September 23, 2003.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The requestor's records are extremely extensive and they are to be commended for keeping such good records. However, the records do not indicate that the care received was reasonable. The patient apparently suffered a sprain/strain type of injury and the level of care rendered does not match the type of injury received. While care on a sprain/strain is reasonable in many instances, it is not documented as to why such

extensive care was rendered to a patient with such uncomplicated symptoms. As a result, the reviewer finds that the care rendered was neither reasonable nor necessary in this case.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,