

MDR Tracking Number: M5-04-1797-01

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 18, 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 myofascial release, manual traction, durable medical equipment, unlisted therapeutic procedures and unusual travel 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 03-10-03 to 08-13-03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 13th day of May 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division
PR/pr

April 26, 2004
Amended May 6, 2004

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

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IRO #: 5251

___ 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

___ was working on a tortilla processing line when the machine malfunctioned and a dough ball, weighing about 30 pounds, was tossed at her. She caught the dough ball and twisted, dropping the dough ball when a second one was tossed to her from the machine. She complained of abdominal pain and low back pain that day and right leg pain was also reported. She continued to work for about a month, but was taken off of work at that point due to pain. Records indicate that she was treated at the ___ by ___ with passive and active care as well as chiropractic therapy. She eventually underwent IDET therapy, which did not improve her symptoms. She also had a rhizotomy at the time of the IDET. As there was no improvement in her condition, ___ recommended a lumbar myelogram, which indicated small ventral defects at L5/S1, L4/5 and L3/4. The post-myelogram CT was specific for a central/left central protrusion at L5/S1 that was about 3 mm in extent. The patient saw ___, a neurosurgeon, on May 28th of 2003 and it was noted that conservative care had failed. He recommended that the patient undergo a lumbar interbody fusion at the level of L4/5 and L5/S1 and the use of the pedicle/screw instrumentation. A second opinion was performed by ___, who indicated on June 27th of 2003 that he agreed that all conservative care as well as the IDET had failed and that the patient was a candidate for the surgical intervention in the lumbar spine. Apparently the patient had a Required Medical Examination with ___, MD in 2002 which was disputed by the treating doctor. A designated doctor, ___, who specialized in orthopedic surgery, examined the patient in February of 2003 and found that she should consider spinal surgery and was not at MMI at that point in time. A review of chiropractic services was performed by ___ and he recommended 36 office visits to be completed no later than October 31, 2002.

DISPUTED SERVICES

The carrier has denied the medical necessity of myofascial release, manual traction, durable medical equipment, unlisted therapeutic procedures and unusual travel as medically unnecessary.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The reviewer finds that the treatment rendered was not appropriate in this case. The numerous doctors who had examined this patient made it very clear that conservative care was having no positive effect on this case. This included both a designated doctor of the TWCC and the referral doctors of the requesting clinic. Clearly, this patient was not responding to the care and the records that were presented for review did reflect such a scenario. As a result, the reviewer finds that the care was neither reasonable nor necessary.

___ 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,