

MDR Tracking Number: M5-04-1909-01

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 2-26-04.

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 work hardening program, functional capacity evaluation, and work related or medical disability exam from 7/25/03 through 9/19/03 was 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, the request for reimbursement for dates of service 7/25/03 through 9/19/03 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 5th day of July 2004.

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

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

June 4, 2004

Re: IRO Case # M5-04-1909 amended 6/26/04

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 service 7/25/03-9/19/03
2. Explanation of benefits
3. MDR request 2/25/04
4. Letter of medical necessity 12/5/03
5. FCE report 6/25/03, 8/12/03, 9/2/03
6. TWCC 69 forms
7. IR report 9/19/03
8. Records from treatment provider
9. WC/WH program daily notes
10. Report 6/3/03
11. Records from medical center
12. Electrodiagnostic study report 6/6/03

History

The patient injured his back in ___ when he was moving some boxes weighing ten pounds and felt a sharp pain in his low and mid back. He went to a medical center that day for examination, x-rays and medication. He then sought care from the treating D.C.

Requested Service(s)

Work hardening, FCE, work related or medical disability exam 7/25/03-9/19/03

Decision

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

Rationale

The patient received a fair trial of chiropractic treatment prior to the dates in dispute. The documentation presented for this review for the treatment prior to the disputed services was poor, and lacked subjective complaints and specific, quantifiable findings to support continued a continued supervised therapy program. Given the patient's limited response to a supervised therapy program, a work hardening program was not medically indicated. The need for such a program is usually based on a good response to past treatment. Failed treatment does not establish a medical rationale for additional non-effective treatment or therapy. The patient canceled several scheduled work hardening treatments for personal reasons. The patient was also significantly overweight, (6' and 265 lbs.) yet there was no documentation related to nutritional counseling or the mention of a weight loss program, which probably would have benefited the patient. The patient had a diagnosed sprain/strain injury that should have resolved with appropriate care prior to the dates in dispute. A home-based exercise program, a supervised weight loss program and appropriate chiropractic treatment should have been beneficial to the patient, without a highly structured work hardening program and FCE.

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