

MDR Tracking Number: M5-04-2034-01

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 May 16, 2003.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. 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 was the only issue** to be resolved. The office visits, myofascial release, joint mobilization, electrical stimulation, chiropractic manipulation treatment spinal, and neuromuscular re-education from 06-18-02 through 06-28-02 and therapeutic activities (97530) from 06-18-02 and 06-19-02 **were found** to be medically necessary. The office visits, myofascial release, joint mobilization, electrical stimulation, chiropractic manipulation treatment spinal, and neuromuscular re-education from 07-01-02 through 11-21-02 and the remaining therapeutic activities from 06-20-02 through 11-21-02 **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for listed services.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this Order. This Order is applicable to dates of service 06-18-02 through 06-28-02 as determined by the IRO decision in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 2nd day of August 2004.

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

July 9, 2004

**NOTICE OF INDEPENDENT REVIEW DECISION
Amended Letter**

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___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 51 year-old female who sustained a work related injury on ___. The patient reported that while at work she injured her back when she attempted to lift a child over a gate. The patient has reportedly undergone x-rays of the cervical, thoracic and lumbar spine. X-ray findings have included straightening of the cervical spin, mild inter-space narrowing at the C5-C6 level, anterior wedge deformity at the T8 level with an upper endplate Schmorl's node, and a limbus at the upper anterior corner of the L4 level. The diagnoses for this patient have included thoracic strain/sprain, lumbar strain/sprain, lumbar disc syndrome, cervical segmental dysfunction, and myospasm. Treatment for this patient's condition has included electrical stimulation, ultrasound, spinal manipulation, myofascial release and therapeutic massage.

Requested Services

OV, ther act, myofas rel, joint mobil, elec stim, chiro man treatment spinal, and neuro reed from 6/18/02 through 11/21/02

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. No documents submitted

Documents Submitted by Respondent:

1. Letter from ___, D.C.
2. SOAP notes 6/19/02 – 11/21/02

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is partially overturned.

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a 51 year-old female who sustained a work related injury to her back on ___. The ___ chiropractor reviewer indicated that 7 months after the date of injury, the patient began treatment with chiropractic care and accompanying modalities. The ___ chiropractor reviewer noted that throughout the course of this treatment the patient had continued complaints and the same palpation findings of tenderness, muscle spasms and hypertonicity. The ___ chiropractor reviewer explained that these findings do not support long-term, ongoing care. The ___ chiropractor reviewer noted that throughout the care the patient received multiple modalities. However, the ___ chiropractor reviewer explained that the patient had the same findings for months, along with the same procedures for months, revealing a patient who has not received significant benefit from chiropractic care. The ___ chiropractor reviewer also explained that the American College of Orthopedic and Environmental Medicine guidelines, as well as the Mercy Guidelines call for a short course of chiropractic care for this patient's condition. The ___ chiropractor reviewer noted that the Mercy Guidelines recommended a short trial course of two weeks each using alternative manipulation procedures before considering treatment to have failed. The ___ chiropractor reviewer explained that without evidence of improvement, spinal manipulation is no longer indicated. The ___ chiropractor reviewer also explained that the patient required a maximum of 6 visits from initiation of care that included chiropractic manipulation as well as two therapeutic activities. The ___ chiropractor reviewer further explained that the patient had not made significant improvement and that additional care would not have changed the treatment outcome. Therefore, the ___ chiropractor consultant concluded that the ov, myofas rel, joint mobil, elec stim, chiro man treatment spinal, and neuro reed from 6/18/02 through 6/28/02 were medically necessary to treat this patient's condition. The ___ chiropractor consultant also concluded that the therapeutic activities (97530) on 6/18/02 and 6/19/02 were medically necessary to treat this patient's condition. However, the ___ chiropractor consultant further concluded that the ov, myofas rel, joint mobil, elec stim, chiro man treatment spinal, and neuro reed from 7/1/02 through 11/21/02 were not medically necessary to treat this patient's condition, and that the remaining therapeutic activities from 6/20/02 through 11/21/02 were not medically necessary to treat this patient's condition.

Sincerely,