

MDR Tracking Number: M5-04-2266-01

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 23, 2004.

In accordance with Rule 133.307 (d), requests for medical dispute resolution are considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute. The Commission received the medical dispute resolution request on 05-23-04, therefore the following date(s) of service are not timely: 02-07-03 through 03-21-03

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 Level III office visits, therapeutic exercises, massage therapy, electrical stimulation, myofascial release, ultrasound and electrical stimulation (unattended) 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 03-24-03 to 05-08-03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 10th day of June 2004.

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

May 26, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

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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 25 year-old female who sustained a work related injury on ___. The patient reported that while at work she injured her low back when she attempted to stop a resident from falling to the ground. The patient underwent an MRI of the lumbar spine on 11/20/02 that was reported to have shown a 1mm posterior bulge at L3-L4, and a 1-2 symmetrical bulge at L5-S1. An EMG/NCV performed on 3/29/03 was reported to have shown no evidence of radiculopathy. The diagnoses for this patient have included muscle spasm, multiple subluxations of the thoracic and lumbar spine, sprain/strain back, post-traumatic synovitis and myofasciitis, post-traumatic arthritis, and post-traumatic myofasciitis. Treatment for this patient's condition has included chiropractic treatments, physical therapy, and medications.

Requested Services

Level III office visits, therapeutic exercises, massage therapy, electrical stimulation, myofascial release, ultrasound, and electrical stimulation (unattended) from 3/24/03 through 5/8/03.

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

Documents Submitted by Requestor:

1. Review of Medical History & Physical Exam 3/14/03, 2/12/03
2. Patient Daily Progress notes 10/10/02–5/6/03

Documents Submitted by Respondent:

1. No Documents Submitted

Decision

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

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a 25 year-old female who sustained a work related injury to her low back on ___. The ___ chiropractor reviewer also noted that the diagnoses for this patient have included muscle spasm, multiple subluxation of the thoracic and lumbar spine, sprain/strain back, post traumatic synovitis and myofasciitis, and post traumatic arthritis. The ___ chiropractor reviewer further noted that treatment for this patient's condition has included chiropractic treatments, physical therapy, and medications. The ___ chiropractor reviewer indicated that the patient had been treated for more than 5 months prior to the dates of service in question.

The ___ chiropractor reviewer explained that the patient showed no subjective relief on her daily SOAP notes and there were no follow up exams or objective findings that documented improvement or that care would have lead to a resolution of her condition. The ___ chiropractor reviewer explained that an EMG/NCV performed on 3/29/03 was negative, the patient was found to be at maximum medical improvement on 5/29/03, and that an MRI of the spine failed to show any nerve root or cord compression to justify this patient's pain pattern. The ___ chiropractor reviewer noted that the patient rated her pain at the same level during treatment from 10/10/02 through 5/12/03. The ___ chiropractor reviewer explained that this patient failed to show any objective or subjective improvement with treatment rendered. Therefore, the ___ chiropractor consultant concluded that the level III office visits, therapeutic exercises, massage therapy, electrical stimulation, myofascial release, ultrasound, and electrical stimulation (unattended) from 3/24/03 through 5/8/03 were not medically necessary to treat this patient's condition.

Sincerely,