

MDR Tracking Number: M5-04-2463-01

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 April 7, 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 ultrasound, electrical stimulation, myofascial release, therapeutic exercises and level III office visits 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 07-02-03 to 07-25-03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 7th day of July 2004.

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

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

June 10, 2004

Re: IRO Case # M5-04-2463-01

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 physician who is 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 7/2/03 – 7/25/03
2. Explanation of benefits
3. Letter from respondent 5/17/04
4. Statement from treatment provider attorney
5. Report 10/2/03
6. Treatment notes from treatment provider
7. Reports 8/26/03, 11/11/03
8. Work hardening notes from treatment provider

History

The patient injured his lower back in ___ when he was pulling cement hoses out of a truck. He initially saw M.D.s and began medication and recommended physical therapy. He was referred to another M.D. who performed three epidural steroid injections. He began treatment with the treating D.C. in March 2003 after the injections failed to be beneficial. He had been evaluated with MRI and discogram, and had been treated with medication, chiropractic treatment and a work hardening program prior to the dates in dispute.

Requested Service(s)

Ultrasound, electrical stimulation, myofascial release, therapeutic exercises, level III office visits 7/2/03-7/25/03

Decision

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

Rationale

The patient received a fair trial of chiropractic treatment for two months prior to the initiation of a work hardening program in May 2003. He attended around 20 work hardening sessions before resuming chiropractic treatment, which included the disputed dates of service. The lumbar epidural steroid injections were performed in November and December 2002 and failed to be beneficial, as did the work hardening program. The failure of conservative therapy modalities does not establish a medical rationale for additional non-effective therapy. The prognosis for successful chiropractic treatment and work hardening with a patient with a confirmed broad-based posterolateral disk protrusion at the L4-5 level deforming the L5 nerve root sleeve, facet arthropathy at the L5-S1 level, and another bulge at the L3-4 level, would be poor at best. The treating D.C. should have realized this before resuming failed chiropractic treatment for the dates in dispute. The medical records provided for review failed to show any lasting relief of symptoms prior to and including the dates in this dispute. The patient's ongoing and chronic care did not produce measurable or objective improvement.

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