

**THIS DECISION HAS BEEN APPEALED. THE FOLLOWING
IS THE RELATED SOAH DECISION NUMBER:**

SOAH DOCKET NO. 453-05-3038.M5

MDR Tracking Number: M5-04-2956-01

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 4-29-04.

The following disputed date of service was withdrawn by the requestor on October 15, 2004 and therefore will not be considered in this review:
CPT code 99213 for date of service 10/8/03.

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 therapeutic exercises and activities, myofascial release, joint mobilization, office visits, and functional capacity evaluation from 5/5/03 through 10/8/03 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 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 5/5/03 through 10/8/03 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Findings and Decision is hereby issued this 18th day of October 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division

RLC/rlc

July 9, 2004

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-04-2956-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.:

Dear

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's
Information provided by Requestor: office notes, physical therapy notes, FCE/EMG-NCV, operative and radiology reports.
Information provided by Respondent: correspondence and designated doctor exam.

Clinical History:

Patient underwent active and passive physical medicine treatments, X-rays, MRI, EMG, FCE and lumbar ESI after sustaining injury to her back and left wrist at work on ___.

Disputed Services:

Therapeutic exercises and activities, myofascial release, joint mobilization, office visits and FCE during the period of 05/05/03 through 08/08/03.

Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were not medically necessary in this case.

Rationale:

Based on the history given, it is reasonable to assume that a regimen of physical medicine treatment should be attempted. However, that initial treatment, consisting of both active and passive care, was performed in March 2003 without success and the patient was referred out for pain management. Two units of therapeutic exercises (97110) were performed on most dates of service, resulting in unsuccessful treatment.

The submitted medical records fail to objectively document that the patient obtained relief from the treatments in question, that promotion of recovery was accomplished or that there was any enhancement of the employee's ability to return to employment. The need for subsequent lumbar ESI further indicates that the treatment was not materially beneficial to the patient.

According to the AHCPR¹ guidelines, spinal manipulation was the only recommended treatment that could relieve symptoms, increase function and hasten recovery for adults suffering from acute low back pain. There was no medical basis to repeat the previously attempted and unsuccessful treatment.

¹ Bigos S., Bowyer O., Braen G., et al. Acute Low Back Problems in Adults. Clinical Practice Guideline No. 14. AHCPR Publication No. 95-0642. Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services. December, 1994.