

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER: 453-04-0988.M5

MDR Tracking Number: M5-04-3313-01

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 June 1, 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 office visits, therapeutic exercises and activities, direct myofascial release, and joint mobilization, 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 06-13-03 to 06-25-03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 6th day of September 2004.

Medical Dispute Resolution Officer
Medical Review Division

PR/pr

August 10, 2004

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

Re: Medical Dispute Resolution
MDR #: M5-04-3313-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: 5055

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: correspondence, office notes/therapeutic exercises, FCE, operative and radiology reports.

Information provided by Respondent: designated doctor exam.

Information provided by Pain Management Specialist: office notes and operative reports.

Information provided by Spine Surgeon: office notes.

Information provided by Neurologist: office notes.

Clinical History:

The records provided for review indicated the claimant sustained a compensable low back injury during the course and scope of his on ____. All medical records indicate the mechanism of injury was a slip and fall. The worker's injuries apparently did not require emergency medical services. He received appropriate exigent medical attention. This provider referred the worker for an appropriate trial of physical therapy services.

Appropriate diagnostic imaging was carried out on 12/04/01 (MRI), which revealed "disc herniation" at L5-S1 discs and disc protrusion at L4-L5 discs. The worker changed treating doctors on 01/07/02 and sought chiropractic. The treating chiropractor subsequently administered a course of chiropractic services. The patient's condition failed to respond to conservative treatment, and he eventually underwent advanced invasive medical pain management (ESI x3) and interbody fusion at L4-L5, L5-S1. Maximum medical improvement was determined by a commission-appointed designated doctor on 12/17/03. A 14% whole person impairment rating was awarded.

Disputed Services:

Office visits, therapeutic exercises and activities, direct myofascial release, and joint mobilization during the period of 06/13/03 through 06/25/03.

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:

The services in question were not documented as medically necessary, and were grossly and flagrantly inappropriate. A reasonable trial of manual therapy (conservative chiropractic management) would have been limited to the time frames proposed in evidence-based disability guidelines, the commission's spine treatment guidelines, current peer-reviewed medical literature, and the chiropractic professions own consensus documents (the Mercy Center conference guidelines). The patient's condition failed to respond to a reasonable course of chiropractic care. Chiropractic services after 03/07/02, thus during the period in dispute 06/13/03 through 06/25/03, were not documented as medically necessary services by the chiropractic provider.

Sincerely,