

MDR Tracking Number: M5-04-3362-01

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 3, 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 visit, therapeutic procedures, therapeutic exercises, myofascial release, therapeutic activities, special reports and manual therapy techniques **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 were not found to be medically necessary, reimbursement for dates of service from 06-09-03 to 08-22-03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 31st day of August 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

PR/pr
Enclosure: IRO decision

August 27, 2004

Ms. Rosalinda Lopez
Texas Workers Compensation Commission
MS48
7551 Metro Center Drive, Suite 100
Austin, Texas 78744-1609

NOTICE OF INDEPENDENT REVIEW DECISION
Amended Letter

RE: MDR Tracking #: M5-04-3362-01
TWCC #:
Injured Employee:
Requestor: Joe L. Garza, D.C.
Respondent: ARCFMI
MAXIMUS Case #: TW04-0337

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS 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 MAXIMUS for independent review in accordance with this Rule.

MAXIMUS 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 MAXIMUS 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 MAXIMUS 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 MAXIMUS for independent review. In addition, the MAXIMUS chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 23 year-old female who sustained a work related injury on _____. The patient reported that while at work she was unloading a shopping basket when she injured her low back and right shoulder. Initial treatment for this patient's condition had included physical therapy and medications. A MRI of the lumbosacral spine performed on 2/28/03 was reported to have shown disc bulges at L4-5 and L5-S1 and neuroforaminal stenosis bilaterally at L5-S1. On 5/22/03 the patient underwent the first in a series of three lumbar epidural steroid injections for the diagnoses of lumbar radiculopathy with nerve root dysfunction.

Requested Services

Office visit, therapeutic procedures, therapeutic exercises, myofascial release, therapeutic activities, special reports, and manual therapy techniques from 6/9/03 through 8/22/03.

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

Documents Submitted by Requestor:

1. Case History 4/26/04
2. Initial Evaluation 6/12/02
3. MRI report 2/28/03
4. Lumbar Epidural Steroid Injection 6/26/03
5. Progress Notes 6/9/03 – 8/22/03

Documents Submitted by Respondent:

1. Independent Review Summary 7/19/04
2. FCE report 7/22/02, 9/26/02
3. Office Notes 5/31/02 – 5/28/02
4. X-Ray report 2/28/02

Decision

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

Rationale/Basis for Decision

The MAXIMUS chiropractor reviewer noted that this case concerns a 23 year-old female who sustained a work related injury on _____. The MAXIMUS chiropractor reviewer indicated that this patient's care started about 12 ½ months after the original injury date. The MAXIMUS chiropractor reviewer noted that the patient had approximately 19 treatment sessions prior to 6/9/03 and that she had also been receiving treatment in the same facility for a left shoulder injury sustained in a motor vehicle accident. The MAXIMUS chiropractor reviewer indicated that from 6/9/03 through 8/22/03 there are no documented subjective or objective clinical findings to support the need for ongoing care. The MAXIMUS chiropractor reviewer explained that the MRI findings from 2/28/03 were significant as far as a reason for her pain, however do not support the need for continued care. The MAXIMUS chiropractor reviewer also explained that the patient was performing a home based exercise program in the clinic that did not require supervision. The MAXIMUS chiropractor reviewer further explained that the documentation provided does not demonstrate that the patient received lumbar epidural steroid injections or whether she benefited from them.

Therefore, the MAXIMUS chiropractor consultant concluded that the office visit, therapeutic procedures, therapeutic exercises, myofascial release, therapeutic activities, special reports, and manual therapy techniques from 6/9/03 through 8/22/03 were not medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Elizabeth McDonald
State Appeals Department