

MDR Tracking Number: M5-04-3397-01

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 6-7-04.

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 medical conferences and physical medicine services from 12-23-03 through 2-11-04 were not medically necessary.

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, reimbursement for dates of service 12-23-03 through 2-11-04 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 24th day of August 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

DA/da

MEDICAL REVIEW OF TEXAS

[IRO #5259]

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-04-3397-01
Name of Patient:	
Name of URA/Payer:	
Name of Provider:	
Name of Physician: (Treating or Requesting)	

August 12, 2004

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

CLINICAL HISTORY

Record review included: Request for and denial of medical conferences and physical medicine services, orthopedic consultation, orthopedic progress reports, 12/29/03 pre-authorization for pain management program, 01/20/03 and 08/03/03 designated doctor examination reports, 04/28/03 second opinion, 03/17/03 NCE medical review report, 01/30/03 IME report, MRI report, pain management progress notes, operative report and treating doctor's treatment notes.

Patient underwent physical medicine treatments and ESI after slipping on some oil at work on ____ injuring her lumbar spine, left leg and left hip.

REQUESTED SERVICE(S)

Medical conferences and physical medicine services from 12/23/03 through 02/11/04.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

Multiple doctors and reviewers opined that the patient would not benefit from further treatment for a variety of reasons including secondary gain. Based on those opinions from doctors who had examined the patient and/or reviewed the medical records, it could have been foreseen that the patient would not have materially benefited from the pain management program in question. It also noteworthy to mention that the designated doctor – who carries presumptive weight – determined the patient to be MMI well before the treatment in question was performed.

The treatment in dispute was medically unnecessary since, as accurately predicted by multiple reviewers and examiners; it did not meet the required statutory standard¹ because it did not relieve the patient's symptoms (7/10 at the beginning of pain management and 7/10 at termination), did not promote recovery and did not enhance the ability of the patient to return to work.

Moreover, TWCC requires² that certain criteria be met for physical medicine treatment to qualify for reimbursement. Those criteria include: (1) the patient's condition shall have the potential for restoration of function and (2) the treatment shall be specific to the injury and provide for the potential improvement of the patient's condition. Potential for restoration of function is identified by progressive return to function. Without demonstration of objective progress as did not occur in this case, ongoing treatment cannot be reasonably expected to restore the patient's function and thus would be medically unnecessary.

¹ Texas Labor Code 408.021

² 1996 TWCC Medical Fee Guideline, Medicine Ground Rules, Section I, A, page 31.