

MDR Tracking Number: M5-04-4130-01

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 8-4-04.

In accordance with Rule 133.308 (e), requests for medical dispute resolution are considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute. The Commission received the medical dispute resolution request on 8-4-04, therefore the following date(s) of service are not timely and are not eligible for this review: 4-9-03 through 7-30-03

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. 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 was the only issue** to be resolved. The office visits, manual therapy, electrical stimulation, and mechanical traction from 8-7-03 through 10-02-03 **were found** to be medically necessary. The therapeutic exercises and neuromuscular reeducation from 8-7-3 through 10-02-03 **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c); plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 4-9-03 through 9-25-03 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 26th day of October, 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

DA/da

October 15, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-4130-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
___ Case #: 5348

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

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

Clinical History

This case concerns a 34 year-old male who sustained a work related injury on ___. The patient reported that while at work he injured his lumbar spine when he attempted to lift a pallet. The initial diagnoses for this patient included lumbar sprain with spasms. The patient was initially treated with physical therapy and injections. A MRI of the lumbar spine performed on 2/10/03 indicated disc herniation at the L4-5 level, eccentric to the left side and compressing the left L5 nerve root. The current diagnoses for this patient include lumbar disc disorder, lumbago, radiculitis, sacroiliitis, lumbar disc herniation, lumbar radiculopathy, and myofascial pain. Further treatment for this patient's condition has included physical therapy, oral medications, and injections.

Requested Services

Office visits, therapeutic exercises, neuromuscular reeducation, manual therapy, electrical stimulation, and mechanical traction from 8/7/03 – 10/2/03.

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

Documents Submitted by Requestor:

1. Daily Progress Notes 2/7/03 – 4/7/04
2. Initial Medical Report 2/7/03
3. Electrodiagnostic evaluation 3/18/03
4. FCE 3/27/03
5. Impairment Evaluation 11/5/03

Documents Submitted by Respondent:

1. Independent Review Organization Summary 9/10/04
2. X-ray reports 6/6/01, 4/11/02, 4/18/03, 8/16/02, 8/23/02, 2/10/03
3. MRI reports 8/13/01, 2/10/03
4. EMG/NCV report 12/6/01, 3/18/03
5. Myelography report 2/14/02, 2/28/02
6. X-ray Hip arthrograph reports 4/11/02, 4/18/02, 8/16/02

Decision

The Carrier's denial of authorization for the requested services is partially overturned.

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a 34 year-old male who sustained a work related injury on ___. The ___ chiropractor reviewer indicated that prior to 8/7/03 the patient made slow progress with treatment rendered. The ___ chiropractor reviewer explained that the continuation of conservative care was medically necessary. The ___ chiropractor reviewer noted that the patient had 11 injections with minimal relief with the last ten. The ___ chiropractor reviewer explained that the patient has chosen not to have surgical intervention and therefore is receiving care that has provided relief on a periodic basis. However, the ___ chiropractor also explained that because treatment in question is over two years since the date of injury, there is no medical necessity for one on one therapy or neuromuscular reeducation. The ___ chiropractor reviewer indicated that these activities could have learned and performed at home. The ___ chiropractor reviewer noted that the patient's pain level went from a 6/10 to a 3/10 in the months prior to the dates in question. The ___ chiropractor reviewer explained that with these findings, it would be reasonable to expect that further improvement was attainable. The ___ chiropractor reviewer noted that the patient was returned to work on restricted duty. Therefore, the ___ chiropractor consultant concluded that the office visits (999212), manual therapy (97140), electrical stimulation (97032), and mechanical traction (97012) from 8/7/02 through 10/2/03 were medically necessary to treat this patient's condition. The ___ chiropractor consultant further concluded that the therapeutic exercises (97110) and neuromuscular reeducation (97112) from 8/7/03 through 10/2/03 were not medically necessary to treat this patient's condition.

Sincerely,
