

MDR Tracking Number M5-05-0493-01

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 10-08-04.

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 office visits, electrodes, narrative report, electrical stimulation-unattended, manual therapy, therapeutic exercises, manual traction and hot/cold packs 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, reimbursement for dates of service from 01-29-04 to 05-03-04 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Findings and Decision is hereby issued this 29th day of December 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

Date: December 21, 2004

To The Attention Of:

Rosalinda Lopez
TWCC
7551 Metro Center Drive, Suite 100, MS-48
Austin, TX 78744-16091

RE: Injured Worker:

MDR Tracking #: M5-05-0493-01

IRO Certificate #: 5242

Forté has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractor reviewer who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- Short statement from the claims manager of ____
- Reports from Dr. R, D.C.
- Patient prescription for physical therapy by Dr. R
- Daily notes
- Designated doctor examination report dated April 22, 1999
- Several 1 page treatment charts dating multiple dates of service

Submitted by Respondent:

- Table of Disputed Services
- Two 1 page letters from the carrier's attorney
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Clinical History

According to the supplied documentation, it appears that the claimant sustained an injury on ____ while loading lumber, which was a normal job duty. The claimant was initially seen at ____ where he was prescribed medications. Approximately one week later he went to _____. At that time he began receiving chiropractic treatment. The claimant was treated until March of 1999 when he reported he was better and his therapy ceased. The claimant was seen by Dr. G, D.C. on April 22, 1999 who reported the claimant was at maximum medical improvement on March 3, 1999 with a whole person impairment rating of 8%. Around that time Dr. R also performed an impairment rating and reported a 14% whole person impairment. There is no documentation of treatment until January of 2004, when the claimant returned to Dr. R's clinic reporting an exacerbation. The claimant received therapy from approximately January 29, 2004 until May 3, 2004. The documentation ends here.

Requested Service(s)

Office visits (99214, 99212), electrodes (99070), narrative report (99080), electrical stimulation, unattended (G0283), manual therapy (97140-59), therapeutic exercises (97110), manual traction (97012), and hot/cold packs (97010) from 1/29/04 thru 5/3/04.

Decision

I agree with the insurance carrier that the services rendered were not medically necessary.

Rationale/Basis for Decision

According to the objective documentation supplied, the claimant sustained an injury on _____. An MRI report dated 12/3/98 revealed a mild disc bulge with slight lateralization to the right. No herniation was recognized. The claimant underwent a conservative course of chiropractic therapy and was determined to be at maximum medical improvement on 3/3/99. No report of medical treatment was determined for approximately 5 years until the claimant returned to Dr. R's clinic on 1/14/04. While Dr. R reported an exacerbation of the initial injury in _____, no objective documentation was submitted to support that finding. Since the claimant's care was dormant for approximately 5 years, it would be highly unlikely that a mild disc bulge with no herniation would be exacerbated 5 years later. After review of the Official Disability Guidelines as well as Occupational Medicine Practice Guidelines, no long term chiropractic therapy is supported after the initial 2-3 months of therapy. The Official Disability Guidelines states even in the event of a disc herniation (ICD-9 code 722.1), chiropractic therapy would be a total of up to 18 visits over the initial 6-8 weeks, avoid chronicity and gradually fade patient into active self-directed care. No current guidelines would support a sprain/strain exacerbation 5 years post injury. None of the therapy that was submitted for review was objectively documented and is not considered reasonable or medically necessary in order to treat the compensable injury dated _____.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 21 day of December 2004.

Signature of IRO Employee: