

MDR Tracking Number: M5-05-1013-01

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, 133.307 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. This dispute was received on 11-29-04.

On 02-04-05 a request was received from the requestor to withdraw the fee dispute issues, therefore the fee issues will not be part of the review of the disputed services.

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 electrodes, replacement battery, neuromuscular stimulator, neuromuscular re-education, therapeutic exercises and manual therapy technique 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 01-30-04 to 04-29-04 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Findings and Decision is hereby issued this 9th day of February 2005.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

Enclosure: IRO Decision

**IRO Medical Dispute Resolution M5 Retrospective Medical Necessity
IRO Decision Notification Letter**

Date: 1/26/2005
Injured Employee:
MDR : M5-05-1013-01
TWCC #:
MCMC Certification #: 5294

DETERMINATION: Deny

Requested Services:

Please review the items in dispute regarding A4556-electrodes; A4630-replacement battery; E0745-neuromuscular stimulator; 97112-neuromuscular re-education; 97110-therapeutic exercises; 97140-manual therapy technique.

Denied by carrier for medical necessity with "V" codes.

Dates of service in dispute: 01/30/2004 - 04/29/2004

MCMC llc (MCMC) is an Independent Review Organization (IRO) that was selected by The Texas Workers' Compensation Commission to render a recommendation regarding the medical necessity of the above Requested Service.

Please be advised that a MCMC Physician Advisor has determined that your request for M5 Retrospective Medical Dispute Resolution on 12/16/2004, concerning the medical necessity of the above referenced requested service, hereby finds the following:

The medical necessity for the above captioned services for dates of service (DOS) 01/30/2004 to 04/29/2004 is not established.

This decision is based on:

- *Notification of IRO Assignment dated 12/16/2004
- *TWCC-60 stamped received 11/29/2004 7 pgs
- *Hartford Medical Management Center Explanation of Reimbursement for DOS 01/30/2004 to 04/29/2004 67 pgs
- *TWCC MR-117 dated 12/16/2004
- *Work and Accident Clinic letter dated 07/15/2004 6 pgs; Physical Performance Evaluations dated 04/30/2004 11 pgs, 01/28/2004 14 pgs, 03/19/2004 15 pgs; Daily Clinic Notes 12/22/2003 to 05/30/2004 47 pgs
- *Dallas Spine Care Chart Notes 04/08/2004 2 pgs
- *Nerve Conduction Studies and Electromyography dated 02/03/2004 4 pgs
- *MRI Cervical Spine and MRI Lumbar Spine dated 12/16/2003;
- *Raphael Emanuel Office Notes 11/12/2003 and 01/21/2004 5 pgs.
- *Xray reports: Cervical Spine Series, L-Spine, Pelvis done on 10/30/2003 3 pgs
- *TWCC-69 signed 05/03/2004
- *Churchill Evaluation Centers letter dated 04/19/2004 2 pgs
- *David Thorne, MD, Review of History and Physical Exam dated 04/19/2004 2 pgs
- *Arcon Airs Impairment Rating Report dated 04/19/2004 3 pgs
- *TWCC-73s dated 03/03/2004; 04/07/2004, 02/05/2004
- *Angela Upchurch, DC, Statements of Medical Necessity dated 05/03/2004, 01/30/2004
- *Phases Work Accident Clinic notes dated 04/19/2004 to 04/28/2004 4 pgs
- *Rehabilitation Exercise Card for DOS 12/04/2003 to 04/08/2004 13 pgs

Records indicate that the above captioned injured individual was allegedly involved in a work related accident that reportedly occurred on _____. The history reveals that the injured individual was carrying a 150 lb. cast iron pipe and fell into a 3-foot deep ditch. The injured individual was initially treated in an emergency facility. Care began at the administration of the Attending Provider (AP) on or before 11/04/2003. The injured individual presented initially with pain to the neck, low back and right hip. Plain film radiographs of the neck, low back and pelvis revealed no significant abnormalities. Cervical and lumbar MRIs were completed on 12/06/2003, which revealed 1-2mm bulges at C3/C4 and C4/C5, a protrusion or herniation at C5/C6 and a bulge at C6/C7. A lumbar MRI revealed L4/L5 and L5/S1 bulges. The injured individual has also been receiving allopathic care for medication management.

The documentation does not clearly substantiate the medical necessity for the above listed services from 01/30/2004 to 04/29/2004. Specifically, the documentation does not reflect that the injured individual clearly benefited from the initial course of care from both an objective and subjective point of view. The documentation indicates that some minimal objective progress was achieved over the initial course of care. However, the it does not clearly indicate that the injured individual was benefiting from the ongoing course of care from a subjective standpoint. The submitted documentation includes daily notes from Work and Accident Clinic beginning 12/22/2003. Treatment had begun at least six weeks prior, on or before 11/04/2003. There is no initial examination submitted for review. In addition, there are no treatment notes prior to 12/22/2003 included for review. However, as of 12/22/2003, the subjective pain levels were recorded as 6/10. Follow-up dates of service record subjective pain levels generally from 6-7/10 with no clear indications that any subjective relief was being attained. Even as late as 04/29/2004, subjective pain levels were indicated to be generally at 5-7/10. Even with very minimal objective progress documented, in the absence of perceived subjective symptomatic relief, the medical necessity for ongoing care, inclusive of the list of services above, beyond the initial trial of care from 11/04/2003 to 01/29/2004 cannot be certified as medically necessary.

REFERENCES:

References utilized in this review include but are not limited to:

1. The ACEOM Guidelines
2. Health Care Guidelines by Milliman and Robertson Volume 7
3. North American Spine Society Guidelines
4. Guidelines for Chiropractic Quality Assurance and Practice Parameters: Practice Parameters from the proceedings of the Mercy Center Consensus Conference, Agency for Health Care Policy and Research (AHCPR), and Procedural Utilization Guidelines.

The reviewing provider is a **Licensed Chiropractor** and certifies that no known conflict of interest exists between the reviewing **Chiropractor** and any of the treating providers or any providers who reviewed the case for determination prior to referral to the IRO. The reviewing physician is on TWCC's Approved Doctor List.

This decision by MCMC is deemed to be a Commission decision and order (133.308(p) (5)).

In accordance with commission rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent via facsimile to the office of TWCC on this

26th day of January 2005.

Signature of IRO Employee: _____

Printed Name of IRO Employee: _____