

# MEDICAL REVIEW OF TEXAS

[IRO #5259]

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## NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M2-05-0340-01
Name of Patient:	
Name of URA/Payer:	TML Intergovernmental Risk Pool
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Dr. H, DC

December 8, 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,

Medical Director

#### CLINICAL HISTORY

Available documentation received and included for initial and subsequent visit notes from Dr. H (DC), functional capacity evaluation and impairment rating reports (Dr. B, DC), consultation report, Dr. S (MD) with prescription for cervical and lumbar spine MRI's.

Record review reveals the following:

\_\_\_\_, a 63 year old female, injured her low back, neck and left shoulder area while attempting to catch a dog as part of her work as a code enforcer for the City of \_\_\_\_\_. She stepped off a concrete pad, falling onto her right side. She immediately sought care with Dr. H, a chiropractor, who assessed her with moderate sprain/strain injuries to the cervical, thoracic and lumbar spine with associated shoulder girdle myofasciitis and cervicogenic headaches. He placed her on a comprehensive conservative treatment régime, expecting MMI within four to eight weeks. She was taken off work until 11/16/03 when she returned with restricted duties. A functional capacity evaluation on 12/17/03 found the patient unable to perform regular duties and recommended a continued therapy program including therapeutic exercises. MMI was determined as of 3/3/04 and the patient assessed with a 10% whole person impairment comprised of DRE category II assignments for the cervical and lumbar spine. The patient returned to her treating doctor on 5/4/04 complaining of recurring symptoms, especially to the thoracic spine. She was referred to an orthopedics surgeon, Dr. S and was seen on 6/21/04. His assessment was degenerative disc disease cervical / lumbar spine. Plan was for cervical and lumbar spine MRI. Patient was seen again on 7/2/04, treating doctor disagreed with necessity for lumbar spine MRI. patient continued with interscapular complaints, continuing through 10/18/04.

#### REQUESTED SERVICE(S)

Medical necessity of proposed MRI to cervical and thoracic spine.

#### DECISION

Approved. There is establishment of medical necessity for cervical and thoracic spine MRI's.

### RATIONALE/BASIS FOR DECISION

Despite initial positive response to conservative care interventions, the patient continues with difficulties and continues to seek care for ongoing complaints. She has exhausted all lower-level therapeutic intervention options, with only temporary effect. Referral was appropriate and made by the treating doctor to an orthopedic surgeon. It appears that she is heading in the direction of more aggressive pain management requirements. MRI would be appropriate to help facilitate the best direction to take. No previous advanced imaging films have been obtained. At this point it would seem like MRI is a relevant precursor to determining necessity for further more aggressive pain management interventions.

The above analysis is based solely upon the medical records/tests submitted. It is assumed that the material provided is correct and complete in nature. If more information becomes available at a later date, an additional report may be requested. Such and may or may not change the opinions rendered in this evaluation.

Opinions are based upon a reasonable degree of medical/chiropractic probability and are totally independent of the requesting client.

### **References:**

- Hansen DT: Topics in Clinical Chiropractic, 1994, volume one, No. 4, December 1994, pp. 1-8 with the article "Back to Basics: Determining how much care to give and reporting patient progress".
- Haldeman S., Chapman-Smith D, Peterson DM., eds. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen: Giathersburg, MD, 1993;
- Souza T: Differential Diagnosis for a Chiropractor: Protocols and Algorithms, 1997; chapter 1, pp. 3-25.
- Liebenson C. Commentary: Rehabilitation and chiropractic practice. JMPT 1996; 19(2):134140

## YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

**If disputing a spinal surgery prospective decision** a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©).

**If disputing other prospective medical necessity (preauthorization) decisions** a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk  
Texas Workers' Compensation Commission  
P.O. Box 17787  
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

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

Signature of IRO Employee: \_\_\_\_\_

Printed Name of IRO Employee: