MAXIMUS

March 5, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-0519-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
-MAXIMUS----- Case #:

------ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ------ 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. 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 52 year-old male who sustained a work related injury on ------. The patient reported that while at work he was hit by a motor vehicle and repeatedly slammed into a brick wall by the vehicle. The patient sustained injury to his abdominal area, legs, and back. The patient reported that he was taken to the emergency department and underwent emergency surgery two hours later. The patient reported that he was an inpatient at the hospital for 3 months after surgery. The patient reported that one year later he underwent another surgery to his lower right leg. The diagnoses for this patient include displacement of lumbar intervertebral disc, disturbance of skin sensation, thoracic or lumbosacral neuritis or radiculitis, facet syndrome, traumatic amputation of right leg below the knee, and late complication of amputation stump. The patient underwent an MRI that showed that the intervertebral disc space between L3-L4, L4-L5, and L5-S1 have desiccation of normal stature with central disc protrusion of 4-5mm each. The patient was treated with numerous modalities.

Requested Services

Office visits, physical therapy sessions, phonophorosis and phonophorosis supplies from 4/8/02 through 5/8/02.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

Rationale/Basis for Decision

The ------ chiropractor reviewer explained that the treatment from 4/8/02 through 5/8/02 was reasonable and medically necessary to treat this patient's condition. The ------ chiropractor reviewer noted that this patient is a very difficult case. The ------ chiropractor explained that it is difficult to predict how a patient is going to respond to a given treatment. The ------ chiropractor also explained that a negative response to treatment does not negate the value of the treatment. Therefore, the ------ chiropractor consultant concluded that the office visits, physical therapy sessions, phonophorisis and phonophorosis supplies from 4/8/02 through 5/8/02.

Sincerely,

State Appeals Department