MAXIMUS

February 18, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-0868-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
MAXIMUS in each blank below as applicable

------ 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 male who sustained a work related injury on ------. The patient reported that while at work he tripped over some pipes and fell down. The patient reported that he injured his low back and groin area on the left. The diagnoses for this patient included sciatic neuritis complicated by lumbar segmental dysfunction. The patient had an MRI that showed 5mm disc protrusion at L5-S1. The patient has been treated with physical therapy both active and passive.

Requested Services

Joint mobilization, office visits, therapeutic exercises, myofascial release, and manual traction therapy from 12/6/01 through 1/30/02.

Decision

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

Rationale/Basis for Decision

The ------ chiropractor reviewer noted that the patient sustained a work related injury to his back on ------. The ------ chiropractor reviewer explained that the treating chiropractor has provided proper documentation and followed the guidelines for providing the care he has identified to treat this patient's condition. The ------ chiropractor reviewer indicated that the patient was treated with joint mobilization, manipulations, myofascial release and manual traction therapy. The ------ chiropractor reviewer explained that this care was provided in the acute stage of the condition and is medically necessary. The ------ chiropractor reviewer also explained that each service is billed separately for each date of service it was performed. The ------ chiropractor reviewer noted that the records provided do not support the need for therapeutic exercises to be performed on a one on one basis for four units per date of service. The ------ chiropractor reviewer explained that the records provided did not show evidence of a change of condition that warranted four units per date of service. However, the ------ chiropractor reviewer explained that one unit of therapeutic exercise per date of service is medically necessary. Therefore, the ------ chiropractor consultant concluded that one segment of the therapeutic exercises per visit from 12/6/01 through 1/30/02 were medically necessary. The ------ chiropractor consultant also concluded that the joint mobilization, office visits, myofascial release and manual traction therapy from 12/6/01 through 1/30/02 were medically necessary to treat this patient's condition.

Sincerely,

State Appeals Department