MDR Tracking Number: M5-03-0116-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2003 and Commission Rule 133.305 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 8-27-02.

The Medical Review Division has reviewed the IRO decision and determined that the total amount recommended for reimbursement does not represent a majority of the medical fees of the disputed healthcare; therefore, the **requestor did not prevail** in the IRO decision. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The office visits, electrical stimulation, ultrasound, and massage rendered on 8-28-01 through 9-18-01 were found to be medically necessary. The office visits on 9-19-01 through 11-13-01 and the hot/cold packs, ROM, and therapeutic procedures on 8-28-01 through 11-13-01 were not found to be medically necessary. The respondent raised no other reasons for denying reimbursement for these services charges.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this Order. This Order is applicable to dates of service 8-28-01 through 11-13-01 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 21st day of August 2003.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division
DZT/dzt

REVISED 8/15/03
August 5, 2003
IRO Certificate# 5259

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 ___, 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

___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 ___.

CLINICAL HISTORY
___ was injured in a work related accident on ___. He fell 15 to 20 feet from a beam over a pit, which had given way. He struck his abdomen and right rib case on the beam on his way down. He was treated by ___ until 7/23/01. He switched treating doctors to ___ and was first seen by him on 8/7/01; who diagnosed a rib fracture and muscle spasm. Throughout this case file there has appeared to be controversy from various doctors as to whether or not ___ suffered rib fractures. In a report from ___, MD, dated 12/16/02, mention is made of a rib x-ray series which demonstrated healed fractures of T8, 9, 11, and 10, also T7 rib fracture, and costal chondritis.

It is also established that he suffered an umbilical hernia, which was repaired.

REQUESTED SERVICE (S)
Payment for office visits, hot or cold pack therapy, electrical stimulation ultrasound therapy, massage therapy, range of motion, therapeutic exercise from 8/28/01 through 11/31/01.

DECISION
Partial approval of chiropractic care and up to three modalities consisting only of, and as indicated in the doctor's daily treatment notes, electrical stimulation, ultrasound and massage as reasonable and medically necessary from 8/28/01 through 9/18/01.

RATIONALE/BASIS FOR DECISION
Based on the severity of the injuries received, a blow hard enough to result in herniation, having the benefit of hindsight, now knowing that fractures were later discovered, plus costal chondritis, this presents as a complicated case.

According to numerous guidelines, a trial of chiropractic care is a maximum of two-courses of care of 2 weeks each (a total of 4 weeks) consisting of evaluation, chiropractic manipulation, and periodic re-evaluations, with 1-3 modalities per visit, after which in the absence of reasonable improvement chiropractic care is no longer appropriate. As this case was somewhat complicated and also chronic, a longer trial period was appropriate to ascertain the efficacy of care in ___ case. Review of the SOAP data provided by ___ does not support reasonable or significant improvement of the patient's condition by 6 weeks time. In fact, ___ records reflect that approximately

one year later. On 9/13/02, the patient was rating pain at about a 5 in both areas, the exact same rating he gave before starting treatment in 8/01.

Review of the submitted treatment records reveals that therapeutic exercises were allegedly performed with ___, but there is no documentation of the actual performance of same. There is no documentation of exercise treatment plan, of actual exercises performed such as weights, number of repetitions, indications of improvement from same, and there are no re-assessments showing progress towards goals. All care afforded this patient was passive in nature.

The opinions rendered in this case are the opinions of the evaluator. This evaluation has been conducted on the basis of the medical examination and documentation as provided, with the assumption that the material is true and correct. If more information becomes available at a later date, an additional service/report/reconsideration may be requested.

Such information may or may not change the opinions rendered in this evaluation. This opinion is based on a clinical assessment, examination and documentation. This opinion does not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.

Medicine is both an art and a science, and although the patient may appear to be fit to participate in various types of activities, there is no guarantee that the individual will not be re-injured, or suffer additional injury as a result of participating I certain types of activities.

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 15th day of August 2003.