MDR Tracking Number: M5-03-0291-01

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, 2002 and Commission Rule 133.305 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent.

The requestor submitted a medical dispute resolution request on 9/19/02 and was received in the Medical Dispute Resolution on 9/19/02. The disputed dates of service 9/17/01 through 9/25/01 had EOB's showing those dates of service were paid. Verification of receipt of payment from these EOB's was made with the requestor on 3/6/03, therefore the dates of service, 9/17/01 through 9/25/01 will be not be mentioned further in this Finding and Decision.

The 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 office visits with or without manipulations, therapeutic procedure, mechanical traction, electrical stimulation, application of modality, supplies and special reports 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 Division has determined that office visits with or without manipulations, therapeutic procedure, mechanical traction, electrical stimulation, application of modality, supplies and special report fees were the only fees involved in the medical dispute to be resolved. As the treatment was not found to be medically necessary, reimbursement for dates of service from 10/1/01 to 1/4/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 11th day of March 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

February 26, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-0291-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is ___. 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 t

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 female who sustained a work related injury to her low back, bilateral knee, and right ankle on ___. The patient reported that while at work she tripped over a coworker's foot. The patient reported that she fell forward onto both knees and right ankle and then backwards onto the low back. The patient was treated with physical therapy beginning with modalities and manipulation and advancing to a work hardening program. She was also given oral pain medications. The diagnoses for this patient included lumbar strain, mild degenerative spine disease without discopathy, contusion of both ankles with mild underlying chondromalacia, sprain of the right ankle with small avulsion fracture, and chronic inflammatory changes. The patient underwent an MRI.

Requested Services

Office visits with manipulations, therapeutic procedure, mechanical traction, electrical stimulation, application of a modality, supplies, office visits, and special report from 10/01/01 through 1/4/02.

Decision

The Carrier's denial of coverage for these services is upheld.

Rationale/Basis for Decision

The ___ chiropractor reviewer indicated that the documentation provided did not demonstrate the ongoing progress of this patient, recovery, or pain reduction. The ___ chiropractor reviewer explained that the progress notes failed to show exact location, nature, radiation, severity, and quality of the pain. The ___ chiropractor reviewer explained that the documentation provided contained minimal clinical documentation. The ___ chiropractor reviewer also explained that there was little to no updated orthopedic and neurological testing documented from office visit to office visit. The ___ chiropractor reviewer further explained that there is insufficient clinical evidence that supports necessity for care for this patient. Therefore, the ___ chiropractor consultant concluded that the office visits with manipulations, therapeutic procedure, mechanical traction, electrical stimulation, application of a modality, supplies, office visits, and special report from 10/01/01 through 1/4/02 were not medically necessary to treat this patient's condition.

Sincerely,

___