

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-03-3355.M5

MDR Tracking Number: M5-03-0704-01

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 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 and physical therapy sessions 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 and physical therapy session 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 3/19/02 to 9/18/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 6th day of May 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

December 24, 2002

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-0704-01

___ 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 ___ external review panel. ___ 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, ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 24 year-old male who sustained a work related injury on ____. The patient states that he was picking up some pipes when he twisted his back and felt immediate pain. The patient was treated with physical therapy, chiropractic manipulation, steroid injections, and pain medications. The patient has reported that he experiences severe low back pain, radiating down his left leg and is associated with numbness, tingling, and weakness. Impression for this patient is lumbar sprain/strain, lumbar facet disease, sacroiliac joint dysfunction, myofascial pain syndrome. The patient had an MRI that showed a herniated disc.

Requested Services

Office visits and physical therapy session from 3/19/02 through 9/18/02.

Decision

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

Rationale/Basis for Decision

___ chiropractor reviewer determined that the office visits and physical therapy sessions from 3/19/02 through 9/18/02 were not medically necessary for treatment of this patient's condition. ___ chiropractor reviewer noted that the patient sustained a work related injury to his back on ____. ___ chiropractor reviewer also noted that the patient was treated extensively for a period of 6 months with chiropractic care. ___ chiropractor reviewer further noted that the documentation provided did not show any appreciable change in the patient's condition from the treatment rendered. ___ chiropractor reviewer explained that the multidisciplinary approach of care to this patient was appropriate. ___ chiropractor reviewer also explained that after a period of 8-12 weeks of chiropractic manipulation and no appreciable results, chiropractic care is no longer medically necessary. (Mercy Guidelines). Therefore, ___ chiropractor consultant concluded that the office visits and physical therapy session from 3/19/02 through 9/18/02 were not medically necessary to treat this patient's condition.

Sincerely,