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 outpatient services including office visits, x-ray, physical therapy, muscle testing, NCV testing, H/F and reflex study 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 outpatient services 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 3/15/02 to 5/28/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 12th day of May 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

NOTICE OF INDEPENDENT REVIEW DECISION

Date: March 28, 2003

Requester/ Respondent Address: Rosalinda Lopez
TWCC
4000 South IH-35, MS-48
Austin, Texas 78704-7491

RE: MDR Tracking #: M5-03-1347-01
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any

documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a chiropractor/physician reviewer who is board certified in chiropractic. The chiropractor/physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

According to the documentation supplied, claimant injured his back at work while lifting a beam on ___ The claimant presented to ___ for treatment. ___ referred the claimant to ___, who began chiropractic care. A NCV was performed on 01/14/2002 stated the claimant had right L5-L1 nerve root irritation. A MRI was performed on 01/15/2002 that revealed some disc desiccation at L5/S1, but no disc bulge or protrusion was found. The remainder of the study appeared to be pre-existing. After a few months of conservative care, the claimant was about to be discharged when he changed treating doctors. His new doctor became ___. ___ began care with the claimant. Several tests were performed including another NCV on 04/10/2002, which reported left L5-S1 nerve root irritation. An impairment rating was performed by another doctor on 05/10/2002, which gave the claimant a 0% whole person impairment on 02/20/2002. ___ examined the claimant on 04/08/2002 and stated that the claimant had lumbar radiculopathy and facet syndrome. The daily notes from the treating doctor stated that they were trying to get ESIs, but they were denied. The daily notes were essentially reported similar complaints everyday, with the last note stating his pain was a 7/10.

Requested Service(s)

Please review and address the medical necessity of the outpatient services rendered between 03/15/2002 – 05/28/2002.

Decision

I agree with the insurance company that the outpatient services rendered between 03/15/2002-05/28/2002 were not medically necessary.

Rationale/Basis for Decision

The MRI performed on the claimant revealed no protrusion or herniation. It appears the claimant continued to improve with conservative care until it was time to be released. The diagnoses and complaints documented by the treating doctor do not support his treatment with the supplied documentation. The impairment rating was performed by an independent doctor stating the claimant reached MMI of 0% on 02/20/2002. ___ felt the claimant had suffered from a lumbar strain and had had plenty of therapy. There are not enough objective findings to justify ongoing care. The claimant received an adequate trial of conservative therapy and should have been released the week of 03/04/2002 as stated in the notes. The continued passive care, referrals,

NCV test, FCE tests and ongoing passive care is not warranted between 03/15/2002 – 05/28/2002.

This decision by the IRO is deemed to be a TWCC decision and order.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 31st day of March 2003.