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 (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 the chiropractic treatment and services 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 chiropractic treatment and service 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 3/28/02 to 10/22/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 14th day of April 2003.

Noel L. Beavers
Medical Dispute Resolution Officer
Medical Review Division

NLB/nlb

NOTICE OF INDEPENDENT REVIEW DECISION

Date: April 10, 2003

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

RE:
MDR Tracking #: M5-03-1498-01
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 Physical Medicine and Rehabilitation\Chiropractic physician reviewer who is board certified in Physical Medicine and Rehabilitation. The Physical Medicine and Rehabilitation\Chiropractic 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

The claimant is a now 37 year old male who is 5'11" in height and approximately 185 pounds in weight. He has a reported injury date of ___ when he was lifting bundles weighing approximately 50 pounds. While carrying a bundle, he twisted to the left side and felt a hot burning pain in his back. He then developed low back pain and mid back pain. He was followed by 2 MD's for treatment and eventually had a lumbar surgery for L5-S1 disc with fusion in 1995 by the doctor. He also underwent an inguinal hernia repair in 1994 due to this injury also it appears from notes received.

1-12-98 re-exacerbation with constant moderate low back pain/numbness/tingling/weakness and buttock pain reported in notes and also hand/wrist pain, but this is due to another on the job work injury. There is no reported radiation of pain into the lower extremities, no paresthesia. He is on no medication. It is noted he reports allergy to anti-inflammatory medications. Diagnosis given is lumbar pain, post surgery adhesions. Therapy program ordered and treadmill testing prior to exercise program. Screws in fusion should be removed. Note is by the doctor.

9-20-02 treatment note by a Chiropractor is with impression of chronic sprain/strain injury to the lumbar spine. Home exercise program. Physical therapy 3 times a week for 4 weeks with multiple modalities of aquatic therapy, exercises/stretching. Notes present from 9-25-02 to 10-22-02 for 11 sessions and reports are with only slowly improving with this excessive program.

5-27-02 re-assessment note by the Chiropractor reports pain is a 2 on a 1 to 10 scale. He had finished physical therapy sessions once again at 3 times a week for 4 weeks. He orders to continues this conservative care at 3 times a week for another 4 weeks. Patient sees another doctor on this same date. Medication of Skelaxin is ordered and Nexium.

Patient has frequent follow-up visits with the other doctor to follow his skin during phonophoresis cream being used as part of his conservative care program.

Therapy notes continue with multiple modalities and lengthy notes that are similar every note from 9-23-02 to 10-22-02.

Requested Service(s)

Outpatient chiropractic care from 3-28-02 through 10-22-02.

Decision

I agree with the insurance carrier that the chiropractic services from 3/28/02 through 10/22/02 are not medically necessary.

Rationale/Basis for Decision

This patient has chronic pain and should fall under the guidelines of maintenance type care for his flare-ups or exacerbations of low back pain.

These guidelines by Medicare for maintenance care of chronic pain would allow 1 therapy session per month with a maximum of 3 modalities per session.

This patient should be on a home program and have instructions how to perform this program independently. He has a TENS unit and can use this for increased pain as needed.

Literature in the fields of Physical Medicine and Rehabilitation, Physical Therapy, Osteopathic Medicine and Chiropractic Medicine have all shown that modalities beyond 3 per session offer little or no additional benefit to the patient. Therefore, 3 modalities per session are considered the standard of care.

Excessive treatment is not indicated or justified in chronic conditions with this over utilization of modality services, examinations and frequency of both that have been provided and is beyond the standards of care for medical necessity.

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 10th day of April 2003.