MDR Tracking Number: M5-03-1727-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(q)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

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 and manipulations, physical therapy, x-rays and TENS supplies were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for these office visits and manipulations, physical therapy, x-rays and TENS supply charges.

This Finding and Decision is hereby issued this 21st day of May 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

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 10/15/02 through 11/6/02 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 May 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/cl

**NOTICE OF INDEPENDENT REVIEW DECISION**

**Date:** May 19, 2003

**RE: MDR Tracking #:** M5-03-1727-01
**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 Chiropractic physician reviewer. The 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**

It appears the claimant suffered low back pain after moving a rather large heavy stone with coworkers on ___. The claimant went to a local emergency room and then proceeded to ____ where x-rays of the cervical and lumbar spine were performed. I do believe the cervical spine has been ruled noncompensable. The claimant saw the doctor for a neurological consult and at that time he was complaining of low back pain with right lower extremity pain along with some headaches. By report, the lower extremity electrodiagnostic studies were normal. The lumbar MRI revealed disc desiccation at L2/3 and L5/S1; however, there were no herniations or neurocompressive disc lesions noted. An orthopedic consult with the doctor revealed a diagnosis of neck sprain and lumbar discogenic syndrome. A TENS unit and possible epidural steroid injections were recommended. A cervical MRI was done and revealed 3 levels of bulges without evidence of neurocompression. There was evidence in the cervical spine of degenerative joint changes and spurring. The claimant saw the doctor and he recommended lumbar facet injections and I do believe that 5 lumbar facet injections were done on or about 6/28/02. I do believe 2 epidural steroid injections were done as well and the claimant responded to the first epidural steroid injection; however, the second epidural steroid injection was not as successful. A 7/9/02 follow up with the doctor revealed the claimant to be "40% improved" via the injections. The doctor, who is the treating physician at ____, certified the claimant at maximum medical improvement as of about 7/16/02 and gave him 5% whole person impairment rating and returned him to work without restrictions as of 7/22/02. The claimant's main complaint at that time was

simply low back pain and there were no subjective complaints of neck pain or headaches at that time. The claimant has stated that the doctor mentioned something about work hardening; however, there has really been no documentation to support that this type of conversation took place. Another doctor saw the claimant for designated doctor purposes on 8/2/02 and felt the claimant was not at maximum medical improvement and needed an active rehabilitation program.

**Requested Service(s)**

The medical necessity of the outpatient services including office visits, office visits with manipulations, physical therapy, x-rays and TENS supplies from 10/15/02 through 11/6/02.

**Decision**

I disagree with the insurance carrier and find that the procedures and services in question were medically necessary.

**Rationale/Basis for Decision**

My overall decision was based on the fact that the overall weight of the available evidence was in favor of the treating doctor. There is some evidence to suggest that there was some symptom magnification; however, most of the evaluating physicians have felt that treatment was reasonable and medically necessary and the claimant has undergone injections. The designated doctor, felt the claimant was in significant need of an active rehabilitation program to consist of either work hardening or another tertiary level of rehabilitation. It is my opinion that the designated doctor, who actually saw the claimant, has presumptive weight in that the decision for non-authorization of these services should not fall on a peer review decision alone. It is also documented that the claimant is required to function at the heavy to very heavy duty level and the functional capacity evaluation of 10/31/02 revealed him to be functioning at the sedentary level. I do feel that the claimant's efforts would be considered suboptimal because the simple activities of daily living associated with everyday life usually require a person to at least function at the light duty level. Regardless of my opinions on this matter, I do feel that an active rehabilitation program was warranted in that the claimant was not documented to have undergone any type of active rehabilitation to date. It should also be mentioned that a physician advisor with ___ felt that the physical therapy provided by the doctor on the listed dates of services in questions were reasonable and medically necessary. The doctor saw the claimant on 10/19/02 and it does appear that the claimant was still not doing well and by this date the claimant had already undergone a few visits of chiropractic care. The functional capacity evaluation is also of concern because the claimant had already undergone about 11-12 chiropractic visits and was still reportedly functioning at the sedentary level. However, it is still my opinion that the active care was reasonable and medically necessary and warranted in this case. Further care beyond 11/6/02 without significant evidence of improvement via a functional capacity evaluation would not be considered reasonable or medically necessary and this case should be closely monitored from a case management point of view. I would have liked to have seen better documentation of the daily services from 10/15/02 through 11/16/02; however, be that as it may, the majority of the services that were provided were of the active care variety and

this is exactly what the claimant needed. Again, I would highly recommend strong and careful case management in this case with respect to future chiropractic care and rehabilitation because there are, in my opinion, symptom magnification issues that will have to be monitored.