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

SOAH DOCKET NO. 453-03-3859.M5

MDR Tracking Number: M5-03-1770-01

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 chiropractic treatment including, office visits, therapeutic procedures, data analysis, muscle testing, myofascial release, joint mobilization, range of motion testing, manual traction, whirlpool, conductive past/gel, temperature gradient studies and physical performance testing was 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 including, office visits, therapeutic procedures, data analysis, muscle testing, myofascial release, joint mobilization, range of motion testing, manual traction, whirlpool, conductive past/gel, temperature gradient studies and physical performance testing 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 5/22/02 to 8/22/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 30th day of May 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

Enclosure: IRO decision

May 28, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M5 03 1770 01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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 care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Doctor of Chiropractic. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

CLINICAL HISTORY

This patient was lifting heavy equipment on his job and suffered an immediate onset of low back pain. He was treated by ___ at ___ in ___. MRI revealed a lumbar disc herniation at L5/S1 of 3 mm. Electrodiagnostic studies by ___ were negative. A designated doctor, ___ found ___ to be at MMI as of June 18, 2002.

DISPUTED SERVICES

The carrier has denied the medical necessity of office visits, therapeutic procedures, data analysis, muscle testing, myofascial release, joint mobilization, range of motion testing, manual traction, whirlpool, conductive paste/gel, temperature gradient studies and physical performance testing as medically unnecessary from May 22, 2002 through August 22, 2002. The IRO did not review June 25, 2002, as this is a fee dispute.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The reviewer feels that the requestor failed to demonstrated medical necessity for this case. While there does seem to be a discopathy in this case, there is no electrodiagnostic evidence that this is a complicated case. The treatment on this case was in excess of what would be considered reasonable within the Texas Guidelines to Quality Assurance because there is no indication that the patient was significantly improving with the care rendered. The peer review from the carrier was of little help, as the reviewer was not specific regarding recommendations. However, the high level of care rendered on this case was not justified by the documentation presented nor by the doctor's letter of explanation. As a result, none of the reviewed care is considered reasonable and necessary.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,