MDR Tracking Number: M5-03-1911-01

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, 2003 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 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 office visits, physical therapy sessions, supplies and MMI/IR exam were not medically necessary.

Based on review of the disputed issues within the request, the Division has determined that the office visits, physical therapy sessions, supplies and MMI/IR exam were the only fees involved in the medical dispute to be resolved. As the office visits, physical therapy sessions, supplies and MMI/IR exam were **not found to be medically necessary**, reimbursement for dates of service from 3/22/02 through 9/12/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 24th day of June 2003.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

June 17, 2003

Re: IRO Case # M5-03-1911

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic who is licensed by the State of Texas. He or she has signed a certification statement attesting 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 referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

History
The patient injured her head, neck and back on ___ when she slipped on a mat and fell backwards on her back and then struck her head. She had extensive physical therapy and chiropractic treatment. She had numerous examinations from MDs, and MRI of her head and neck and EMG.

Requested Service(s)
Office visits, physical therapy, supply, MMI/R exam 3/22/02-9/12/02.

Decision
I agree with the carrier's decision to deny the requested treatment.

Rationale
The patient had received extensive physical therapy, chiropractic treatment and therapeutic exercises with no documented relief of her symptoms. Extensive testing has shown that very little was clinically wrong with the patient besides her subjective complaints of pain and headaches. MRIS of the brain and cervical spine were negative, as was an EMG.
I question the appropriateness of the care provided to this patient. The documentation presented for this review fails to show any improvement of the patient's neck pain or headaches. On 7/25/02, one of the patient's MDs reported that the frequency of her headaches was increasing. On 6/6/02 the treating chiropractor reported that the patient was still having "severe muscle spasms." On 6/11/02, the pain scale was still rated at 7-8 out of 10. These symptoms persisted after several months of extensive treatment and rehabilitation from the chiropractor.
An Independent Medical Evaluation placed the patient at MMI with 0% impairment on 5/6/02, stating that the patient "fits into DRE I for cervicothoracic and lumbosacral spine disorder, that being symptoms without any objective findings," and that "there is some

evidence of symptom magnification as well." After an MMI date is reached all further treatment must be reasonable and effective in relieving symptoms or improving function. The records do not indicate that any of the disputed treatment was reasonable and effective. The patient's ongoing and chronic care did not appear to be producing measurable or objective improvement, and it did not appear.to be directed at progression for return to work. The documentation presented fails to show how the disputed treatment was necessary.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

Sincerely,

_____