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

SOAH DOCKET NO. 453-04-3029.M5

MDR Tracking Number: M5-03-1925-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General 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. This dispute was received on 08-07-03.

The IRO reviewed office visits, myofascial release, manual traction, electrical stimulation, ultrasound therapy, therapeutic procedures, kinetic activities, office visits with manipulations, and work conditioning rendered from 09-12-02 through 01-10-03 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity for office visits, myofascial release, manual traction, electrical stimulation, ultrasound therapy, therapeutic procedures, kinetic activities, office visits with manipulations, and work conditioning. Consequently, the requestor is not owed a refund of the paid IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On June 16, 2003, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice. The Medical Review Division is unable to review this dispute for fee issues. Documentation was not submitted in accordance with Rule 133.307(l) to confirm services were rendered for dates of service 11-18-03 and 01-10-03, through 01-28-03. Therefore reimbursement is not recommended.

This Decision is hereby issued this 31st day of December 2003.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

June 9, 2003

MDR Tracking #: M5 03 1925 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

The patient was injured when she was lifting at work and picked up a box which weighed 75 pounds. She suffered an immediate onset of pain in the low back, which later included the neck and shoulders. She eventually had a laminectomy/discectomy at L5/S1 which left her in significant pain, with little or no improvement in her condition. She had no rehabilitation from her surgical provider and eventually sought to change doctors to ___, who apparently began treating the patient with modalities and active treatment in the fall of 2002. MRI of the cervical spine is presented that indicates a herniation at C3/C4.

DISPUTED SERVICES

The carrier has disputed the medical necessity of office visits, myofascial release, manual traction, electrical stimulation, ultrasound therapy, therapeutic procedures, kinetic activities, office visits with manipulations and work conditioning from September 12 through January 10, as well as January 14th, 15th, 24th, 27th, and 28th.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

There is no doubt that this patient was injured and that she received care from a surgeon who performed the discectomy. However, the services that are rendered on this case are undetermined because neither the requestor nor responder sent office notes to describe the types of care and the progress from the care on any particular date of injury. While we see significant documentation from specialists and diagnostic centers as to the patient's condition, as well as appeal letters from the treating doctor, we do not see required documentation of the actual service rendered. This is particularly true for the work conditioning program dates, which would indicate a highly structure program that was administered but not documented. As a result, the reviewer is unable to determine the medical necessity of this case and would agree with the prior assessment lacking such documentation.

___ 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 ___, dba ___, 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,