MDR Tracking Number: M5-03-2410-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 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. The dispute was received on 5-29-03.

The Medical Review 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, myofascial release, therapeutic exercises, paraffin bath, electrical stimulation (unattended), ultrasound, and hot/cold packs 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 Medical Review Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service from 9-20-02 to 2-12-03 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 29th day of August 2003.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division
DZT/dzt

July 29, 2003

IRO Certificate# 5259
MDR Tracking Number: M5-03-2410-01

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that

no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY
Based on materials provided for review, it appear that this patient is injured at work on ___ when he was involved in a chemical explosion and experienced multiple burns to his hands, arms, and back. He also allegedly experienced a fall causing contusion and sprain/strain of his lower back. He was admitted to ___ where he received surgery and underwent burn treatment for approximately six weeks. No initial hospital, medical or physical therapy reports are provided for review. In December of 2001 he presented to a chiropractor, ___, was referred for home health care and assistance and was treated with conservative care for lumbar sprain/strain conditions. The patient was sent to ___ for medical assessment. However, these reports are not submitted for review. Patient is also given TENS unit for home use. In March of 2002 the patient began treatment with ___, which consisted mostly of passive modalities. Lumbar MRI performed 6/7/02 suggests moderate degenerative changes without evidence of impingement or gross herniation. There are some chiropractic treatment and daily rehab notes submitted from 10/22/02 to 3/24/03 only. The patient is continued with multiple units of passive therapy in addition to 6 units of therapeutic exercise. Patient's pain levels remain unchanged at 8/10 throughout the course of treatment. No Functional Capacity Evaluation appears to be provided or submitted for review. The patient is referred to ___, for pain management on 8/21/02 and is found to have chronic low back pain due to a ___ work related injury.

REQUESTED SERVICE (S)
Office visits, therapeutic exercises, paraffin bath, myofascial release, electrical stimulation (unattended), ultrasound, and hot/cold packs from 9/20/02 through 2/12/03.

DECISION
Deny.

RATIONALE/BASIS FOR DECISION
Objective imaging and other documentation do not conform discogenic or neurogenic lesions as identified by the treating doctors. There is considerable co-morbidity with extensive burns that are well documented from reported injury; however this does not provide clinical rationale fro continuing passive therapy beyond the natural history for identified sprain/strain conditions. In addition, the relatively unchanged pain levels suggest that these modalities provided little if any lasting or progressive symptom management benefit. There does not appear to be a relative need for active rehabilitation of this patient, however, there is no evaluation of functional deficits necessary to justify the multiple units of therapeutic exercise provided. Also, there appears to be no effort to provide this patient with home exercise instruction and self-care training. The multiple passive modalities and therapeutic exercises provided at 10+ months post-injury are not supported by documentation of medical necessity and clinical rationale.

[AHCPR Low Back Treatment Guidelines, GCQAPP Mercy Center Consensus Conference]

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested.

Such information may or may not change the opinions rendered in this review.

This review and its findings are based solely on submitted materials. No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned claimant. These opinions rendered do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.