MDR Tracking Number: M5-03-2469-01

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 (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 6/5/03.

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, therapeutic procedures, hot/cold packs, electrical stimulation, joint mobilization, massage and myofascial release 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 Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the treatment, office visits, therapeutic procedures, hot/cold packs, electrical stimulation, joint mobilization, massage and myofascial release were not found to be medically necessary, reimbursement for dates of service from 6/5/02 to 8/9/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 22nd day of August 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISED 8/20/03

MDR Tracking Number: M5-03-2469-01
IRO Certificate Number: 5259

August 15,2003

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 Texas Medical Foundation, 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

___ 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 ___.

Sincerely,

CLINICAL HISTORY
Patient experienced low back pain after injury on ___.

REQUESTED SERVICE(S)
Therapeutic procedures, office visits, hot/cold packs, electrical stimulation, joint mobilization, massage, myofascial release from 6/5/02 through 8/9/02.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

Other than slight variations in subjective complaints, the daily progress notes were almost verbatim for each and every visit from 6/5/02 through 8/9/02 (even when Dr. ___ treated the patient). For that reason, legitimate daily progress notes regarding the patient's treatment and response to care were not furnished. Since the daily progress notes did not meet the proper standard of care, there was no documentation supplied to support the medical necessity for any of the treatments performed on the dates in question.