MDR Tracking Number: M5-03-2659-01

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 June 19, 2003.

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 w/manipulations, myofascial release, ultrasound therapy, physical medicine treatment, and therapeutic exercises 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 w/manipulations, myofascial release, ultrasound therapy, physical medicine treatment, and therapeutic exercises was not found to be medically necessary, reimbursement for dates of service 6/20/02 through 9/12/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 5th day of September 2003.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

September 2, 2003

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

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___ 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.

The independent review was performed by a matched peer with the treating doctor. 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 boxes and suddenly had an onset of low back pain. The patient complained of not only pain, but weakness in both legs lacking parasthesia. He began treatment with the ___ shortly after the accident and was treated with chiropractic, medication, passive and active therapy. EMG was performed by ___ and was negative for radiculopathy. No MRI study is presented in this file, but ___diagnosed the patient with myofascial pain syndrome.

DISPUTED SERVICES

Under dispute is the medical necessity of office visits with manipulations, myofascial release, ultrasound therapy, physical medicine treatment, and therapeutic procedures.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

This patient had a sprain/strain type of injury, from the records presented. There is no indication from the records received that the treatment was effective for this patient or that the treating doctor had a specific goal in mind toward this patient's recovery. Of note is the fact that 8-10 months after the date of injury the treating clinic was still performing passive treatment on this patient. The care rendered was not necessary in the opinion of the reviewer and did not effectively treat this injured worker's condition. As a result, the reviewer finds that since the treatment was not within the Mercy or TCA guidelines, the treatment was not reasonable in this particular case.

___ 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,