MDR Tracking Number: M5-03-2720-01

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 6-24-03.

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 aquatic therapy, myofascial release, hot/cold packs, electrical stimulation, neuromuscular re-education, therapeutic activities, and special report 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 medical necessity 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 8-27-02 through 12-2-02 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 4th day of September 2003.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

DZT/dzt

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 a package at work on ___ and had a sudden onset of low back pain. He sought care from the ___ under the direction of ___. He was treated with chiropractic care along with passive and active modalities. He was diagnosed with a sprain/strain injury by his treating doctor. A referral for pain management was made to ___, who diagnosed a radiculopathy and disc herniation. However, no MRI or EMG results are presented in this file. The carrier's review was performed by ___ of ___. She recommended up to 12 treatments that had been done up to the date of the review, plus 2 additional weeks (6 sessions) of therapy and 6 visits per injection for post-injection therapy.

DISPUTED SERVICES

Under dispute is the medical necessity of aquatic therapy, myofascial release, physical medicine treatment, neuromuscular re-education, therapeutic procedures, kinetic activities, office visits, special reports, and office visits with manipulation.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The documentation demonstrates no medical necessity for the care rendered on this case. This patient was diagnosed by his doctor as having a sprain/strain. The length of treatment was inappropriate for this case, especially considering the chronic nature of the patient's low back injuries. The high level of treatment rendered could not be validated by reasonable guidelines, including the TCA guideline. As a result, the treatment rendered is not found to be medically necessary due to a lack of documentation by the treating doctor.

__ 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,