MDR Tracking Number: M5-03-2722-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 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 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, occupational therapy, myofascial release, neuromuscular re-education physical medicine treatment kinetic activities, reports and ultrasound therapy 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 the office visits, therapeutic procedures, occupational therapy, myofascial release, neuromuscular re-education physical medicine treatment kinetic activities, reports and ultrasound therapy fees were the only fees involved in the medical dispute to be resolved. As the treatment was not found to be medically necessary, reimbursement for dates of service from 7/17/02 to 10/17/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 19th day of August 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division
CRL/crl

August 12, 2003

MDR Tracking Number: M5-03-2722-01
IRO Certificate# 5259

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

Patient was diagnosed with lumbar myospasms, sprain/strain of lumbar spine (possible disc herniation), and lumbar radiculopathy following an injury that occurred on ___. Treatment consisted solely of physical medicine procedures with no documentation that chiropractic spinal adjustments were performed at any time.

REQUESTED SERVICE (S)

Medical necessity of all treatment rendered is in dispute from 7/17/02 through 10/17/02. These treatments consisted of therapeutic procedures, occupational therapy, myofascial release, neuromuscular re-education, physical medicine treatment, kinetic activities, office visits, ultrasound therapy, and special reports.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

Documentation fails to substantiate need for myofascial release (soft tissue manipulation) and the re-examination of 7/17/02 makes no mention of persistent muscular spasm. In addition, it is questionable how an individual could participate in kinetic activities and therapeutic exercise for 60-90 minutes with lumbar muscular spasms.

In addition, there is no basis for neuromuscular re-education as the documentation fails to sufficiently indicate what is functioning aberrantly to warrant this procedure, particularly on each and every encounter.

At three months post-injury, continued application of electrical stimulation with accompanying moist heat or cold packs is not indicated. If the heat and cold modalities were needed, they could have been applied at home.

More importantly, the doctor supplied no documentation that chiropractic spinal adjustments were performed at any time. According to the AHCPR guidelines, spinal manipulation was the only recommended treatment that could relieve symptoms, increase function, and hasten recovery. The multiple physical medicine modalities were therefore not indicated.