

MDR Tracking Number: M5-03-2735-01

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 6-19-03.

The Medical Review Division has reviewed the IRO decision and determined that the total amount recommended for reimbursement does not represent a majority of the medical fees of the disputed healthcare and therefore; the **requestor did not prevail** in the IRO decision. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The office visits on 9-4-02, 1-13-03, 1-22-03, 2-5-03, 3-7-03, and 3-17-03 were found to be medically necessary. The injection-Para vertebral nerves, unlisted procedure-nervous system, hot/cold packs, and osteopathic manipulative treatment on 8-7-02 through 4-7-03 were not found to be medically necessary. The respondent raised no other issues for denying reimbursement for the above listed services.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 9-4-02 through 3-17-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 4<sup>th</sup> day of September 2003.

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

**REVISED 8/29/03**

August 20, 2003

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IRO Certificate# 5259

An independent review of the above-referenced case has been completed by a medical physician [board certified] in physical medicine and rehabilitation. 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

This is a gentleman who was reportedly injured on \_\_\_\_. Initially treated with chiropractic modalities, he failed to resolve the symptomology. Imaging studies noted multiple level degenerative changes to the lumbar spine. Electrodiagnostic assessment confirmed this as a lumbar strain. Referral was made from a chiropractor to a Doctor of osteopathic. Very similar treatment modalities were repeated. There was a clear clinical need for the medication and follow-up office visits for medication management.

REQUESTED SERVICE (S)

Medical necessity of the office visits, injection anesthesia, joint mobilization, nervous stimulator, and OMT from 8/7/02 through 4/7/03.

DECISION

Partial approval. Approve office visits. Deny all other treatments as not medically necessary.

#### RATIONALE/BASIS FOR DECISION

1. In as much as multiple medications were being prescribed, office visits would be reasonable and necessary.
2. Injections anesthesia, on multiple visits, with the clear lack of efficacy, is NOT reasonable and necessary care.
3. Joint Mobilization (in this case DMX) is not reasonable and necessary. This device has not been proven and has not demonstrated any efficacy. There are Appeals Panel decisions that have excluded this as part of the armamentarium in this case.
4. OMT is not reasonable and necessary as there was excessive chiropractic mobilization and there was no positive response to this type of treatment.