MDR Tracking Number: M5-03-2749-01

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 office visits, x-rays, physical medicine sessions, and required reports 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 disputed services were not found to be medically necessary. Therefore, reimbursement for dates of service from 9-17-01 through 5-1-02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 11th day of August 2003.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

DZT/dzt

NOTICE OF INDEPENDENT REVIEW DECISION

Date: August 1, 2003

RE: MDR Tracking #: M5-03-2749-01
IRO Certificate #: **5242**

_____ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced 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 proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractic physician reviewer. The Chiropractic physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians 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 this case.

Clinical History

According to the documentation supplied, it appears that the claimant was injured at work on ___ when she slipped and fell. She was seen at the emergency room and was prescribed Motrin. On 05/14/2001, she was evaluated by _______________ who prescribed her medications and a physical therapy program. After undergoing 14 weeks of physical, the claimant changed treating doctors to __________. _____ began using chiropractic therapy on the claimant. She underwent 3 lumbar epidural steroid injections. The claimant underwent multiple diagnostic testing with referrals from _____. Continued active and passive care modalities were continued and medication consults were also done. Functional capacity exams were performed by _____, which did not put her at her normal work capacity. Several designated doctor exams were performed with 0% - 15% whole person impairment ratings. The entire chart was reviewed including information from the provider and insurance carrier.

Requested Service(s)

Please review and address the medical necessity of the outpatient services including office visits, x-rays, therapeutic procedures, therapeutic activities, neuromuscular re-education, hot/cold packs, massage, electrical stimulation, ultrasound, and required reports rendered 09/17/2001 – 05/01/2002.

Decision

I agree with the insurance company, and disagree with the provider, that the services rendered between 09/17/2001 – 05/01/2002 were not medically necessary.

Rationale/Basis for Decision

According to the supplied documentation from both parties, the objective findings do not support the ongoing treatments listed above including; office visits**,** x-rays, therapeutic procedures, therapeutic activities, neuromuscular re-education, hot/cold packs, massage, electrical stimulation, ultrasound, and required reports. The claimant had already undergone enough passive and active modalities related to her compensable injury. There were subjective findings indicating wrist/possible carpal tunnel, but no definitive findings that would relate this to her ___ work injury. The only treatment that would be acceptable and medically necessary more than 6 months post injury would be the treatment that followed the claimant's lumbar injections for a period of 2 weeks post injection. According to the supplied table it appears that the insurance company has decided to pay for that period. Continued ongoing modalities both active and passive 6 – 12 months post injury are not deemed necessary.