MDR Tracking Number: M5-03-2753-01

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 27, 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 therapeutic exercises, myofascial release, neuromuscular re-education, hot or cold packs, electrical stimulation, office visits and computer data analysis 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 therapeutic exercises, myofascial release, neuromuscular re-education, hot or cold packs, electrical stimulation, office visits and computer data analysis were not found to be medically necessary, reimbursement for dates of service from 7/11/02 through 8/21/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 30th day of September 2003.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division
MQO/mqo

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

September 19, 2003

Re: IRO Case # M5-03-2753

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic who is licensed by the State of Texas , and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting 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 referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

History
The patient injured his lower back on ___ while lifting an air conditioning unit. His evaluation included EMG and MRI, and he was treated with physical therapy, chiropractic care, epidural steroid injections, medication and therapeutic exercises. The patient was initially treated by an orthopedic surgeon, who apparently released the patient to work with some lifting restrictions on 2/26/02. The patient was also treated by a pain management specialist. The patient was placed at MMI on 5/20/02

Requested Service(s)
Therapeutic procedure, myofascial release, neuromuscular re-education, hot or cold packs, electrical stimulation, office visit and computer data analysis 7/11/02-8/21/02.

Decision
I agree with the carrier's decision to deny the requested treatment.

Rationale
The patient had extensive conservative therapy for many months without documented relief of symptoms. His pain scale was still 4/10 as of 8/15/02. An 11/14/01 MRI revealed bilateral pars defect at L5-S1 with spondylolisthesis, posterior element arthropathy with bilateral facet hypertrophy, neural foraminal encroachment and L5-S1 disk herniation. These are all pre existing conditions with a superimposed lumbar strain injury, which should have resolved with or without treatment in six to eight weeks post injury. The prognosis for a full recovery for this patient was poor at best, and re-injury is highly

probable with patients such as this patient. This case was not a chiropractic case. The patient was placed at MMI on 5/20/02. After an MMI date is reached all further treatment must be reasonable and effective in relieving symptoms or improving function, and in this case the documentation lacked objective, quantifiable findings to support the requested services.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

Sincerely,