THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-04-0673.M5

MDR Tracking Number: M5-03-2789-01

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 July 1, 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 MRI, whirlpool, physical therapy, office visits, joint mobilization, myofascial release, manual traction, neuromuscular re-education, neurological procedure were not found to be 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 MRI, whirlpool, physical therapy, office visits, joint mobilization, myofascial release, manual traction, neuromuscular re-education, neurological procedure were not found to be medically necessary, reimbursement for dates of service 2/3/03 through 2/19/03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 5th day of September 2003.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M5-03-2789-01

September 3, 2003

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

Available information suggests that this patient was injured at work on ___ when he fell from a ladder onto a concrete surface. He was seen initially at a hospital ER, then later at a chiropractic office on 1/8/03. No ER or other medial records are submitted for review. There are a number of documents submitted from ___ and ___, suggesting that the patient is seen for low back pain, right foot/ankle pain and wrist pain. The patient apparently begins treatment with ___on 9/9/03 with multiple passive and active modalities. An MRI is performed 2/3/03 suggesting essentially normal findings. There are a number of ROM tests and Strength Testing reports submitted from 1/9/03 through 3/10/03. Doctor's notes suggest that the patient is not showing any significant progress. There is a Sensory Nerve Conduction Threshold (CPT) test apparently performed 2/7/03 suggesting mild hypoesthetic conditions, but no clinical rationale or clinical correlation of findings is provided. A functional Capacity Evaluation appears to be performed 3/4/03. There are also a great deal of undated and unsigned Ergos Work Performance Tests provided by ___. This file also contains a number of unsigned Static Strength and ROM Tests dated from ***1/5/80***, ***1/6/80***, and ***8/8/80***. It is undetermined as to what relation these dates have to these reported conditions. There are also a number of unsigned, clearly computer generated chiropractic office notes, submitted by ___, identifying the patient's gender as ***Female*** from 1/8/03 to 3/12/03. Multiple passages in chiropractic notes indicate that ***Mr.*** ___ describes pain ***she*** is having to ***her*** lumbar spine, right foot and right hand. The patient is diagnosed with lumbar disc disorder, non-specific paresthesia, tenosynovitis of the foot/ankle and contusions of the hand/wrist. The patient is apparently treated with myofascial release, joint mobilization, manual traction and multiple units of therapeutic exercise. Frequency of treatment is requested at 5x per week for 2 weeks; then 4x per

week thereafter with anticipated release date of 4/30/03. The patient was also apparently referred to ___, for medical pain assessment, but no report of this evaluation is provided for review. Specific chiropractic reporting from 2/3/03 to 2/19/03 suggests no clear clinical rationale for tests performed and services provided. No change or measurable improvement of these conditions is noted in this reporting. In fact, chiropractic reporting appears essentially identical for each date during this period of care.

REQUESTED SERVICE(S)

Medical necessity for chiropractic services rendered (magnetic imaging, portable whirlpool, physical therapy, office visits, joint mobilization and neurological procedures) 2/3/03 through 2/19/03.

DECISION

Deny. Chiropractic reporting does not support medical necessity or established clinical rationale for these services provided.

RATIONALE/BASIS FOR DECISION

1. Hurwitz EL, et al. The effectiveness of physical modalities among patients with low back pain randomized to chiropractic care: Findings from the UCLA Low Back Pain Study. J Manipulative Physiol Ther 2002; 25(1):10-20

2. Morton JE. Manipulation in the treatment of acute low back pain. J Man Manip Ther 1999; 7(4):182-189.

3. Bigos SJ et al. Acute Low Back Problems in Adults: Assessment and Treatment, AHCPR Publication No. 95-0643, Dec. 1994.l

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials. No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned claimant. These opinions rendered do not constitute a per se recommendation for specific claims or administrative functions to be made or enforced.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.