MDR Tracking Number: M5-03-3161-01

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 8-4-03.

The Medical Review 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, joint mobilization, spray and stretch, electrical stimulation, and aquatic 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 Medical Review Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service 3-31-03 through 5-12-03 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 17th day of September 2003.

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

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

September 12, 2003

Re: IRO Case # M5-03-3161-01

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 ___ when he lifted a tire with another person and felt pain in his lower back. On 2/14/01 he was diagnosed with lumbar strain and was prescribed medication. He presented to the treating chiropractor on 2/28/01. An MRI was done on 2/15/01and electodiagnostic studies were performed on 7/25/01. The patient ws placed at MMI on 6/12/01. The patient received chiropractic treatment from 2/28/01 through the dates in dispute 3/31/03 through 5/12/03

Requested Service(s)
Electrical Stimulation, aquatic therapy, spray & stretch, office visits, joint mobilization, therapeutic exercises

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

Rationale
The patient had received extensive chiropractic treatment, physical therapy and aquatic therapy for a diagnosed lumbar strain. The 2/15/01 MRI report noted disk desiccation at L4-5 and L5-S1, hypolorodosis suggesting musculoligamentous strain with no distinct herniated disk. The documentation provided indicates that the patient sustained nothing more than a lumbar strain superimposed on lumbar degenerative disk disease, and that it should have resolved within two months of the date of injury.
The patient was placed at MMI on 6/12/01. He qualified for very heavy work capacity on

4/24/02. The patient was examined on 4/29/02 and it was noted that the patient had zero pain and should be released from care.
The patient continued to have recurring flare-ups of his lower back which, it appears from the documentation provided, is a result of degenerative disk disease of the lumbar spine. Flare ups are very common with people with degenerative changes of the spine. The patient had received virtual resolution of the original soft tissue injury, was pain free, and able to return to very heavy work. Flare ups are appropriately treated with rest, home exercise and OTC medication. In all probability this patient will continue to have flare ups. Frequent return to a DC for flare ups is not necessary. A home-based exercise program, which could include swimming, probably would be appropriate and beneficial to the patient. The patient had plateaued in a diminished condition months prior to the dates in dispute. The documentation provided for review does not support the ongoing and chronic care provided and did not produce measurable or objective improvement, and was not provided in the least intensive setting.

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

Sincerely,