MDR Tracking Number: M5-03-3271-01

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 8-13-03.

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, range of motion testing, muscle testing, therapeutic exercises, group therapeutic procedures, myofascial release, joint mobilization, and miscellaneous supplies 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 from 8-13-02 through 1-14-03 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 6th day of November 2003.

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

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

October 30, 2003

Re: IRO Case # M5-03-3271 Amended

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 her left shoulder, wrist and lower back in ___, when she fell on a wet floor. She has had an MRI of the left shoulder and lumbar spine, and has been treated with physical therapy, chiropractic manipulation, medication, injections, and surgery on her left wrist.

Requested Service(s)
Office visits, ROM-separate body areas, muscle testing, group therapeutic procedures, myofascial release, joint mobilization, therapeutic exercises and supplies (analgesic balm) 8/13/03-1/14/03

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

Rationale
Based on the records provided for this review, the patient had extensive treatment from the requesting clinic with minimal, if any relief of symptoms or improved function. A 7/2/03 states that, "she has completed 69 sessions of physical therapy with minimal relief."

The patient's pain scale was 5/10 on 7/16/02 and remained so throughout the dates of the treatment in dispute. Her subjective complaints and objective findings never changed. If anything, the patient's physical and mental condition deteriorated during this treatment period. A 12/26/02 report stated that, "she ambulates with a walker," and that the patient has weakness in her left arm, fingers, wrist, ankle, knee and hip, and decreased sensation in her hand. The patient could not walk on her heals or toes due to instability. The examining physician found that the patient was depressed, upset, had feelings of hopelessness, worthlessness, guilt, thoughts of suicide and was sleeping only two hours per night because of her pain. These are all signs and indications that treatment at the clinic had failed. There had been no relief of symptoms or improved function.

Based on the records provide, it appears that the patient had plateaued in a diminished state prior to the dates in dispute, and any further chiropractic treatment was unreasonable and ineffective in relieving symptoms or improving function. The chronic and ongoing treatment failed to produce any measurable or objective improvement. The muscle testing and range of motion testing were over utilized and, based on the records provided, were inappropriate, lacking objective findings to support their use. Analgesic balm would not be of benefit. The treatment clinic failed to show how the disputed services were medically necessary.

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

Sincerely,