MDR Tracking Number: M5-03-3297-01

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 8/15/03.

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 myofascial release, electrical stimulation, neuromuscular re-education, therapeutic procedures and activities, whirlpool therapy, gait training, aquatic therapy and joint mobilization 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 myofascial release, electrical stimulation, neuromuscular re-education, therapeutic procedures and activities, whirlpool therapy, gait training, aquatic therapy and joint mobilization were not found to be medically necessary, reimbursement for dates of service from 8/21/02 through 4/11/03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 7th day of November 2003.

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

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

November 3, 2003

Re: IRO Case # M5-03-3297

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 lower back in ___ when she fell out of a chair. She was treated with physical terapy, percutaneous lumbar denervation, lumbar facet joint injections and medication. A CT scan was obtained.

Requested Service(s)
Myofascial release, electric stimulation, neuromuscular reeducation, therapeutic procedures and activities, whirlpool joint mobilization, aquatic therapy, gait training 8/21/02-4/11/03

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

Rationale
The patient had extensive chiropractic and medical treatment without documented relief of symptoms or improved function. As of 7/23/03, some three months after the last date in this dispute, the patient's pain level was still 8/10.
The efficacy of chiropractic manipulation and aquatic therapy is very doubtful on a

patient with confirmed lumbar disk bulges and disk protrusions at multiple levels with an annular tear at L5-S1.

The medical necessity of prolonged physical therapy and chiropractic manipulation beyond the usual standard for treatment of chronic back pain is not supported by the records provided for this review, or by chiropractic literature.
The patient had an adequate trial of conservative treatment prior to the dates in dispute without documented relief of her symptoms or improved function. Joint mobilization, myofscial release and some forms of therapeutic exercises would be contraindicated in a patient presenting with this patient's symptoms and disk pathologies. The ongoing and chronic care did not produce objective or measurable 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,