MDR Tracking Number: M5-03-3329-01

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 8-20-03.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Disputed dates of service 8-9-02 through 8-16-02 are over the one year filing deadline and were not reviewed. The IRO agrees with the previous determination that the office visits, therapeutic activities, therapeutic procedures, myofascial release, and required report 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 8-21-02 through 10-18-02 is denied and the Medical Review Division declines to issue an Order in this dispute.

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

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

October 29, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-3329-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception

to the ADL requirement. The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a male who sustained a work related injury on ___. The patient reported that while at work he was unloading furniture from a truck when he began to experience low back pain. An MRI of the lumbar spine from 4/16/01 showed a 4mm central disc herniation at the L4-L5 levels and a 3mm central disc herniation with desiccation of disc material and loss of disc height at L5-S1. An EMG from 4/22/02 demonstrated a bilateral L5 and S1 radiculopathy. The diagnoses for this patient has included lumbar disc syndrome, lumbar radiculitis and muscle spasms. The patient was treated with epidural steroid injections, passive and active rehabilitation and chiropractic manipulation.The patient also completed a work hardening program.

Requested Services

Office visits 99211, therapeutic activities 97530, therapeutic procedures 97110, myofascial release 97250 and medical report 99080-73 from 8/21/02 through 10/18/02.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is upheld.

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a male who sustained a work related injury on ___. The ___ chiropractor also noted that the diagnoses for this patient included lumbar disc syndrome, lumbar radiculitis and muscle spasms. The ___ chiropractor reviewer further noted that the treatment for this patient's condition has included epidural steroid injections, passive and active rehabilitation and chiropractic manipulation. The ___ chiropractor reviewer explained that the patient made no additional progress with treatment. The ___ chiropractor reviewer also explained that the patient reported an increase in pain with treatment. The ___ chiropractor reviewer further explained that the treatment provided over this period never changed despite that patient making no progress. Therefore, the ___ chiropractor consultant concluded that the office visits 99211, therapeutic activities 97530, therapeutic procedures 97110, myofascial release 97250 and medical report 99080-73 from 8/21/02 through 10/18/02 were not medically necessary to treat this patient's condition.

Sincerely,