MDR Tracking Number: M5-03-3375-01

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 7-1-03.

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 therapeutic exercises, hot/cold packs, electrical stimulation, work hardening, and physical performance (FCE) testing 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 7-1-02 through 9-13-02 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 3rd day of February 2004.

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

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

November 11, 2003

Re: IRO Case # M5-03-3375

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 right knee and lower back on ___ when he slipped and fell. He received chiropractic treatment through 4/8/02. The patient was recommended for work conditioning 4/29/02-5/16/02, and according to the then treating D.C. and was close to MMI and return to work. The patient changed his treating doctor on 5/20/02 and began chiropractic treatment and physical therapy. A work hardening program was started on 8/5/02 and lasted through 9/13/02.

Requested Service(s)
Therapeutic exercise, hot or cold packs, electrical stimulation, work hardening, physical performance testing 7/1/02-9/13/02

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

Rational
The patient received very extensive chiropractic treatment, physical therapy, work conditioning and work hardening for a diagnosed lumbar and right knee sprain/strain. In the final FCE performed on 9/13/02, the patient's endurance was graded at poor, he was unable to complete a repetitive task because of low back pain, he had decreased right knee ranges of motion, and he had an Oswestry pain rating of severe. All of these are indications that the treatment failed to be beneficial to the patient.
I question the appropriateness of the disputed care. The documentation provided for this review is repetitive, very limited in detail and lacks specific, objective, quantifiable findings to support the necessity of continued treatment after completion of the work conditioning program on 5/17/02. The rationale for the continued treatment was not documented. Based on the records provided, the disputed treatment was excessive, over utilized, and encouraged doctor dependency.

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