

MDR Tracking Number: M5-03-0230-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 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 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 office visits, therapeutic procedures, joint mobilization, electrical stimulation and ultrasound 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 office visits, therapeutic procedures, joint mobilization, electrical stimulation and ultrasound fees were the only fees involved in the medical dispute to be resolved. As the treatment was not found to be medically necessary, reimbursement for dates of service from 9/13/01 to 10/1/01 is denied and the Division declines to issue an Order in this dispute.

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

Noel L. Beavers  
Medical Dispute Resolution Officer  
Medical Review Division

NLB/nlb

February 27, 2003

Rosalinda Lopez  
Texas Workers' Compensation Commission  
Medical Dispute Resolution  
4000 South IH-35, MS 48  
Austin, TX 78704-7491  
Fax: 512.804.4868

Re: Medical Dispute Resolution  
MDR #: M5.03.0230.01  
IRO Certificate No.: 5055

Dear Ms. Lopez:

\_\_\_ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, \_\_\_ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is a Chiropractic doctor.

Clinical History:

This 43-year-old male reported an injury to his lower back and left shoulder on \_\_\_. According to radiology review, he did have some bulging discs in his lower spine that were consistent with someone of his age. He began on 08/03/01, consisting of heat, ultrasound, E-stim, exercises and joint mobilization. Treatment was continued for a period of eight weeks.

Disputed Services:

Office visits and physical therapy from 09/13/01 through 10/01/01.

Decision:

The reviewer agrees with the determination of the insurance carrier. The reviewer is of the opinion that the treatment in question was not medically necessary.

Rationale for Decision:

Given the type of injury, the patient should have had resolution in six weeks of treatment. Different malingering tests were positive. The patient also exhibited pain behavior features. He was given a 5% impairment rating for his low back. Six weeks of care was substantial for this injury, and the last two weeks were not medically necessary.

I am the Secretary and General Counsel of \_\_\_ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,