MDR Tracking Number: M5-03-0312-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Therefore, in accordance with §133.308(q)(9), the Commission **Declines to Order** the respondent to refund the requestor for the paid IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The therapeutic procedures, office visits, myofascial release, physical medicine, electrical stimulation and manipulations were found to not be medically necessary. The respondent raised no other reasons for denying reimbursement.

This Finding and Decision is hereby issued this 17th day of December 2002.

Noel L. Beavers
Medical Dispute Resolution Officer
Medical Review Division

NLB/nlb

December 10, 2002

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

Re: Medical Dispute Resolution
MDR#: M5-03-0312-01
IRO Certificate No.: IRO 5055

Dear:

___ 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 certified in Chiropractic medicine.

Clinical History:
This male claimant sustained an injury to his lower back on ___ while on his job, resulting in pain in the low back on standing. Therapeutic procedures, myofascial release, physical medicine, electrical stimulation and manipulations were methods of treatment beginning 03/18/02, and continuing through 07/09/02.

Disputed Services:
Services from 05/30/02 through 07/09/02, which include therapeutic procedures, office visits, myofascial release, physical medicine, electrical stimulation and manipulation.

Decision:
The reviewer agrees with the determination of the insurance carrier. The reviewer is of the opinion that the treatments and procedures in question were not medically necessary in this case.

Rationale for Decision:
Appropriate treatment was rendered from 03/18/02 until 05/30/02. No supporting documentation was provided for continuation of treatment after 05/30/02. The period of 03/18/02 until 05/30/02 is enough treatment time for passive/active and rehabilitative care. If more treatment was medically necessary, additional information supporting the continued treatment was not presented.

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 who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,