MDR Tracking Number: M5-03-0355-01

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 the physical therapy (including therapeutic exercise, myofascial release, electrical stimulation and physical medicine procedures) rendered was not medically necessary.

Based on review of the disputed issues within the request, the Division has determined that physical therapy (including therapeutic exercise, myofascial release, electrical stimulation and physical medicine procedures) fees were the only fees involved in the medical dispute to be resolved. As the treatment, (physical therapy - including therapeutic exercise, myofascial release, electrical stimulation and physical medicine procedures) was not found to be medically necessary, reimbursement for dates of service from 5/3/02 through 5/24/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 22nd day of November 2002.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

November 20, 2002

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M5 03 0355 01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Doctor of Chiropractic. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

The claimant injured his low back region when he fell from a stool. There was the indication of radicular symptoms which were documented. However, no tension signs were evident. There were no muscle spasms documented. The orthopedic evaluation could be suggestive of sacroiliac joint involvement. The MRI and EMG/NCV studies were considered relatively normal. Furthermore, this claimant has undergone ample physical modalities (active and passive), medication treatment as well as ESI therapy. There was also extensive diagnostic testing/procedures to determine the source of his complaint, yet the subjective complaints remain despite all the intervention.

DISPUTED SERVICES

The carrier has denied therapeutic exercise, myofascial release, electrical stimulation and physical medicine procedures as medically unnecessary from May 13, 2002 to May 24, 2002.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

With regard to the therapeutic exercise and myofascial release treatments, these procedures are for strengthening regions that are deficient or stretching regions that are taut, in spasm, restricted, etc. Due to the lack of objective evidence documented, these procedures would not be supported.

The muscle stimulation/ultrasound combination procedures are for reduction of muscle spasm and/or to decrease swelling primarily. This type of procedure can also reduce pain, but this is secondary to the above. Due to a lack of objective evidence documented, these procedures would not be supported. There were no myospasms and/or swelling documented or indicated.

The claimant objectively demonstrated a retained S1/S2 disc or partial fusion of the S1 segment at the top of sacrum, a reflex deficit with associated "numbness" and "minimal" loss of spinal motion, secondary to pain. However, imaging (MRI) was considered normal and the EMG/NCV study was considered normal and there were no myospasms documented. The majority of this case is based on subjective perception of pain. However, there was no supportive documentation for any of the therapies/physical modalities indicated (active or passive).

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,