

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-03-2981.M5

MDR Tracking Number: M5-03-0680-01

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 and physical therapy 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 and physical therapy 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 4/15/02 to 5/23/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 26th day of March 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

March 13, 2003

**NOTICE OF INDEPENDENT REVIEW DECISION
Addendum to Determination**

RE: MDR Tracking #: M5-03-0680-01

___ 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 physician on ___ external review panel. This physician is board certified in physical medicine and rehabilitation. ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician 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, ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 50 year-old female who sustained a work related injury on ____. The patient reportedly injured her back and underwent back surgery in 2001 and 2002. The diagnosis for this patient is thoracic/lumbar disc displacement. The patient has a past medical history of L4-L5 and L5-S1 fusion in 1991. The patient was treated with physical therapy and a chronic pain management program that ended March 2002. The patient received further physical therapy beginning 4/15/02.

Requested Services

Office visits and physical therapy from 4/15/02 through 5/23/02.

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

___ physician reviewer noted that the patient had sustained a work related injury on ____. ___ physician reviewer also noted that the patient had a past medical history of L4-L5 and L5-S1 fusion. ___ physician reviewer indicated that the patient was treated with physical therapy beginning 4/15/02. ___ physician reviewer explained that the documentation provided did not show the patient's progress with the office visits and physical therapy program. ___ physician reviewer also explained that the patient suffers from a chronic pain problem and failed back surgery. However, ___ physician reviewer indicated that ongoing physical therapy is not indicated for the treatment of chronic pain or failed back surgery. Therefore, ___ physician consultant concluded that the office visits and physical therapy from 4/15/02 through 5/23/02 were not medically necessary to treat this patient's condition.

Sincerely,

—