MDR Tracking Number: M5-03-0931-01

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 therapeutic procedure, electrical stim, phonophoresis, and myofascial release 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 therapeutic procedure, electrical stim, phonophoresis, and myofascial release 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 7/19/02 to 7/24/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 14th day of April 2003.
Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

February 26, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-0931-01

___ 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 the ___ external review panel. This physician is board certified in physical medicine and rehabilitation. The ___ 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, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 55 year-old female who sustained a work related injury to her back on ___. The diagnosis for this patient is degeneration intravertebral disc and lumbar spondylosis. The patient underwent surgery 4/25/02 for a L5-S1 herniated disc removal. Physical therapy was prescribed 4 weeks post surgery for 4 weeks in duration. The patient returned to the treating physician 7/10/02 with radicular findings. The patient was prescribed 4 additional weeks of therapy for treatment of the radicular findings, post herniated disc removal.

Requested Services

Therapeutic procedure, electrical stimulation, phonophoresis, and myofascial release from 7/19/02 through 7/24/02.

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

The ___ physician reviewer noted that the patient sustained a work related injury to her back on ___. The ___ physician reviewer also noted that the patient underwent surgery on 4/25/02 for a L5-S1 herniated disc. The ___ physician reviewer indicated that the patient was treated 4 weeks post surgery for weeks in duration with physical therapy. The ___ physician reviewer also indicated that an additional 4 weeks of physical therapy were prescribed for radicluar findings post herniated disc removal. The ___ physician reviewer explained that the daily notes provided only described the patient's symptoms. The ___ physician reviewer also explained that the documents provided did not contain an initial evaluation or any other exam data from prior to 7/19/02. The ___ physician reviewer further explained that it is unclear whether the services from 7/19/02 through 7/24/02 were indicated. Therefore, the ___ physician consultant concluded that the therapeutic procedure, electrical stimulation, phonophoresis, and myofascial release from 7/19/02 through 7/24/02 were not medically necessary to treat this patient's condition.

Sincerely,

___