MDR Tracking Number: M5-03-1261-01

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 electrical stimulation, therapeutic exercises/activities and mechanical traction 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 electrical stimulation, therapeutic exercises/activities and mechanical traction 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 7/8/02 to 10/9/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 16th day of June 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

June 6, 2003

Re: IRO Case # M5-03-1261-01

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Physical Medicine and Rehabilitation. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient is a 23-year-old male who on ___ was lifting and unloading a large television. He bent and felt a pop in the low back with acute and immediate onset of pain in his low back, buttock and right leg. He sought medical treatment, and physical therapy was started on 4/15/02. A physical performance evaluation on 4/30/02 demonstrated that the patient was unable to tolerate any of the positions or activities required for his job, and he was unable to lift any significant weight. He was taken off work. Extensive diagnostic testing was performed, but only some of the reports were presented for this review. A sensory nerve study was performed and sensory nerve involvement was found and rated as severe and profound. A motor nerve conduction velocity study was negative for peripheral nerve involvement. An MRI of the lumbar spine on 6/13/02 was reportedly positive for disk protrusions at L4-5 and L5-S1 with moderate foraminal stenosis at L4-5 bilaterally and milder changes at L5-S1. Two epidural steroid injections were administered without significant benefit. A neurosurgical consultation was done and the neurosurgeon reported that the patient's MRI and myelogram showed only mild bulging disks without significant foraminal or central canal stenosis. An EMG of the lower extremities showed abnormalities. The patient has been unable to work since his injury due to symptoms, which he describes as pain in the low back radiating down his right leg.

Requested Service(s)

Electrical stimulation, therapeutic exercises & activities, mechanical traction 7/8/02-10/9/02

Decision

I agree with the carrier's decision to deny the requested treatment.

Rationale

The patient sustained an injury to his low back on ___. He was treated with physical therapy beginning 4/15/02. He underwent multiple physical performance evaluations

> throughout his care. On each evaluation he was unable to perform the tasks required or even to tolerate sedentary activities. His job requires a heavy physical demand level. On each evaluation there is no change in his lifting ability or ability to perform tasks. There is no medical necessity for the patient to continue physical therapy three months after its initiation when the documentation shows no benefit. The clinical notes from the treating physician failed to document any need for continued physical therapy beyond the initial period. The documentation provided fails to show any reason to continue physical therapy three months after an injury when the patient clearly is not benefiting from treatment.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

Sincerely,