

MDR Tracking Number: M5-03-1381-01

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, 2003 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 physical therapy and chiropractic treatments 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 physical therapy and chiropractic treatment 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 5/7/02 to 7/24/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 19th day of May 2003.

Noel L. Beavers
Medical Dispute Resolution Officer
Medical Review Division
NLB/nlb

May 15, 2003

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

MDR Tracking #: M5-03-1381-01
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.

The independent review was performed by a matched peer with the treating doctor. 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

___ was injured on ___ and seen by ER and her company doctor. She had some physical therapy and was sent back to work. She then went to ___, who treated her and put the patient on a program which involved mechanical traction, electric muscle stimulation, ultrasound, therapeutic exercise (5 units), therapeutic massage, and several office visits with manipulation. The carrier disputes the procedures as medically unnecessary.

DISPUTED SERVICES

Under dispute is the medial necessity of physical therapy and chiropractic treatments rendered from 5/7/02 through 7/24/02.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

While there are numerous records for review, the procedures in question are very specifically pertaining to the treatment dates of 5/7/2002 through 7/24/2002. These procedures involved therapeutic exercise, mechanical traction, electric muscle stimulation, ultrasound & therapeutic massage. Certainly at this point in treatment, passive therapies are no longer indicated, and there was no documentation of the type of therapeutic exercises being performed by the patient, nor of the weights (if applicable), repetitions, or sets. Such records generally show a progression, which indicates improvement, or an inability to progress, which could indicate the need for further evaluation. Also included were several chiropractic manipulations, for which no record indicating necessity or response to treatment was provided. I have, therefore, recommended denial of these procedures because medical necessity has not been established.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy

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,