

MDR Tracking Number: M5-03-1663-01

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 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 aquatic therapy, massage therapy, office visits, and therapeutic exercises 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 the aquatic therapy, massage therapy, office visits, and therapeutic exercises 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 8/9/02 through 9/25/02 are denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 27th day of May 2003.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division
MQO/mqo

NOTICE OF INDEPENDENT REVIEW DECISION

May 22, 2003

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
4000 South IH-35, MS 48
Austin, TX 78704-7491

RE: MDR Tracking #: M5-03-1663-01
IRO Certificate #: IRO4326

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced 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 rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___'s health care professional has signed a certification statement stating 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 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 this case.

Clinical History

This patient injured himself on the job ___ when he was carrying some plywood. He slipped, fell into a ditch, and the wood fell on him. He immediately reported pain in his lower back and left leg. MRI on 05/09/00 revealed herniated nucleus pulposus at L4-L5 and degenerative disc changes. The patient underwent a lumbar laminectomy, decompression, diskectomy L4-L5 with fusion on 09/11/00. He had a replacement of his spinal cord stimulator synergy battery on 06/18/02.

Requested Service(s)

Aquatic therapy, massage therapy, office visits, and therapeutic exercises from 08/09/02 through 09/25/02.

Decision

It is determined that the aquatic therapy, massage therapy, office visits, and therapeutic exercises from 08/09/02 through 09/25/02 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

Based upon the review of the provided records it was not medically necessary for this patient to receive aquatic therapy, massage therapy, office visits, and therapeutic exercises from 08/09/02 through 09/25/02 as it relates to the injury of ___.

Although the patient had lumbar spine surgery on 09/11/00, there is no standard of care that supports the performance of aquatic therapy, massage therapy, office visits, and therapeutic exercises to continue two years and four months after the date of the injury. All reasonable and necessary treatment as it relates to this injury should have been completed.

The replacement of the spinal cord stimulator battery on 06/18/02 was not sufficient to warrant the aquatic therapy, massage therapy, office visits, and therapeutic exercises. Therefore, the aquatic therapy, massage therapy, office visits, and therapeutic exercises from 08/09/02 through 09/25/02 were not medically necessary.

Sincerely,