MDR Tracking Number: M5-03-1701-01

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 was 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 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 12/10/02 to 12/20/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 21st day of May 2003.

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

NOTICE OF INDEPENDENT REVIEW DECISION

Date: May 19, 2003

RE: MDR Tracking #: M5-03-1701-01
IRO Certificate #: **5242**

___ 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 proposed 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 an orthopedic surgeon physician reviewer who is board certified in orthopedic surgery. The orthopedic surgeon physician reviewer 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
Claimant reportedly sustained an injury to lower back in a slip and fall at work on ___. The claimant received treatment for injuries and returned to work. The claimant had complaints of chronic pain and was evaluated again in November of 2002 at which time additional physical therapy was prescribed. At the time the additional physical therapy was prescribed the claimant exhibited normal neurologic exam. Claimant exhibited some decreased active lumbar extension but showed good lumbar rotation bilaterally, and good sacral mobility.

Requested Service(s)
Physical therapy rendered from 12/10/02 to 12/20/02.

Decision
I agree with the insurance carrier that the physical therapy treatments and services rendered from 12/10/02 to 12/20/02 are not medically necessary.

Rationale/Basis for Decision
There is no clearly documented clinical rationale to explain why a well structured home exercise program emphasizing therapeutic exercise would be any less effective then active intervention in this clinical setting.