MDR Tracking Number: M5-03-1737-01

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 medical treatment including modalities, physical therapy and therapeutic activities 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 medical treatment including modalities, physical therapy and therapeutic activity 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 9/24/02 to 11/20/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 15th day of July 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

July 14, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-1737-01

____ 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 a board certified orthopedic surgeon. 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 41 year-old male who sustained a work related injury on ____. The patient reported that while at work he fell down after loading heavy bags of sand. The patient initially underwent X-Rays and was diagnosed with discogenic low back pain. The patient was treated with rest, hot/cold compress and physical therapy. On 8/15/01 the patient underwent an MRI and was referred for epidural steroid injections followed by a course of physical therapy.

Requested Services

Medical treatment including modalities, physical therapy and therapeutic activities from 9/24/02 through 11/20/02.

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 this case concerns a 41 year-old male who sustained a work related injury to his back on ____. The ____ physician reviewer also noted that the patient has a long history of back pain and eventually underwent an IDET on 8/9/02. The ____ physician reviewer indicated that the post surgical diagnosis for this patient is stiffness. The ____ physician reviewer also indicated that the patient was treated post surgically with physical therapy that included myofascial release, ultrasound and electrical stimulation. The ____ physician reviewer explained that passive modalities such as ultrasound, myofascial release and electrical stimulation are of very little use to regain motion after surgery when dealing primarily with stiffness. The ____ physician reviewer also explained that it would not be unreasonable to have a patient undergo physical therapy post surgically. However, the ____ physician reviewer further explained that the physical therapy should be tailored to the patient's needs. Therefore, the ____ physician consultant concluded that the medical treatment including modalities, physical therapy and therapeutic activities from 9/24/02 through 11/20/02 were not medically necessary to treat this patient's condition at this time.

Sincerely,

____