MDR Tracking Number: M5-03-2059-01

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 physical medicine treatment, therapeutic exercises, neuromuscular re-education, electrical stimulation, ultrasound, myofascial release, office visits with manipulations 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 physical medicine treatment, therapeutic exercises, neuromuscular re-education, electrical stimulation, ultrasound, myofascial release, office visits with manipulations 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 5/20/02 through 12/9/02 is denied and the Division declines to issue an Order in this dispute.

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

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

June 26, 2003

Re: Medical Dispute Resolution
MDR #: M5-03-2059-01

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is Certified in Chiropractic medicine.

Clinical History:
This male claimant fractured his right tenth rib and injured his thoracic and low back area in an on-the-job accident on ___. He received four months of treatment with no significant changes in his objective and subjective findings, and his symptoms, muscle spasms, edema, and tenderness in the thoracic and lumbar spine areas.

Disputed Services:
Physical medicine treatment, therapeutic exercises, neuromuscular re-education, electrical stimulation, ultrasound myofascial release, and office visits w/manipulations during the period of 05/20/02 through 12/09/02.

Decision:
The reviewer agrees with the determination of the insurance carrier. The reviewer is of the opinion that the treatments and services in question were not medically necessary in this case.

Rationale for Decision:
The patient received almost four months of treatment with no significant improvement. His pain level remained between 7 and 8 on a scale of 15.

According to the *National Spine Society Treatment Guidelines*, this patient is considered chronic due to the length of time from the date of injury and the persistent symptomatology. In addition, four months with no significant changes in symptoms and objective findings does not substantiate medical necessity of continued treatment. The lack of documented progress in objective and subjective findings establishes that there is no medical necessity for the treatment rendered from 05/20/02 through 12/09/02.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,