MDR Tracking Number: M5-03-2447-01

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 office visits, massage therapy, ultrasound, electrical stimulation, 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 office visits, massage therapy, ultrasound, electrical stimulation, therapeutic exercise 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 3/4/03 to 4/9/03 is denied and the Division declines to issue an Order in this dispute.

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

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division
CRL/crl

July 29, 2003

IRO Certificate# 5259
MDR Tracking Number: M5-03-2447-01

An independent review of the above-referenced case has been completed by a medical physician [board certified] in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY

25-year old male status post 4foot fall on ___. Four hours later severe lower back pain, negative lumbar x-ray for fractures, no neurological deficit with mild, alternating left and right, subjective positive straight leg raise. Electrodiagnostic testing on 3/11/03 revealed mild chronic bilateral L5-S1 radiculopathy without active nerve denervation. MRI on 2/10/03 showed L3, L4, and L5 disc herniation, all mild.

REQUESTED SERVICE (S)

Massage therapy, ultrasound therapy, electrical stimulation, therapeutic exercises, and office visit.

DECISION

Uphold denial of services.

RATIONALE/BASIS FOR DECISION

According to the Agency for Health Care Policy and Research Guidelines, by normal history this patient should have improved already, prior to the disputed services. The therapeutic algorithm should have been re-directed and progressive pain control was not utilized i.e. opioids. According to ___ et al., patients optimally recover if assigned to an appropriate flexion or extension group, for exercise; this patient was not. Lastly, the patient has no convincing evidence for an acute radiculopathy, i.e. no denervation on EMG, no reflex changes and no weakness (objective) on exam. Furthermore, disc herniation, according to ___, on MRI, can show up to 40% false positives in people without pain what so ever.