MDR Tracking Number: M5-03-2504-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General 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 dispute was received on 3-6-03.

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 office visits and physical therapy 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 medical necessity was the only issue to be resolved. The requestor stated that payment had been received for disputed dates of service 3-28-02 and 7-17-02. As the treatment was not found to be medically necessary, reimbursement for dates of service from 5-10-02 through 6-12-02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 29th day of August 2003.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division
DZT/dzt

August 15, 2003

MDR Tracking Number: M5-03-2504-01
IRO Certificate# 5259

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___ 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
Repetitive use disorder treated with chiropractic, physical medicine modalities, injections, medications, and surgery.

REQUESTED SERVICE (S)
Physical therapy and office visits from 5/10/02 through 6/12/02.

DECISION
Denied.

RATIONALE/BASIS FOR DECISION
There is insufficient documentation to support the medical necessity of continued care for the dates in question. Moreover, since this type of treatment was previously unsuccessful, no documentation was supplied to indicate that the patient would now respond favorable to the same treatment.