MDR Tracking Number: M5-03-2904-01

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 (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 7-11-03.

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 the office visits, physical medicine modalities, ultrasound, myofascial release, therapeutic activities, therapeutic exercises, neuromuscular reeducation, and special supplies 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 fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service from 8-7-02 to 12-18-02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 25th day of August 2003.

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

August 20, 2003

MDR Tracking Number: M5-03-2904-01
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
Patient received rehabilitation treatment after lumbar surgery on ___.

REQUESTED SERVICE (S)
Office visits, physical therapy sessions and special supplies from 8/7/02 through 12/18/02.

DECISION
Denied.

RATIONALE/BASIS FOR DECISION
Although the physician's 7/8/02 treatment plan of 12 post-surgical rehabilitation visits (3xs per week for 4 weeks) was indicated, there is no documentation supporting further care after that time. Since the physician failed to record lumbar ranges of motion on 7/8/02 (after the surgery intervention), there is no base line to quantitatively measure response to the care. Moreover, when lumbar ranges of motion were recorded later (9/5/02 and 10/21/02), there was no significant improvement during that time frame, indicating the rehabilitation treatment had little to no beneficial effect.