MDR Tracking Number: M5-03-2943-01

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 7-14-03.

The Medical Review 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, aquatic therapy, massage, therapeutic exercises, and electrical stimulation 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 Medical Review 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 8-6-02 through 8-13-02 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 10th day of September 2003.

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

NOTICE OF INDEPENDENT REVIEW DECISION

September 4, 2003

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
4000 South IH-35, MS 48
Austin, TX 78704-7491

RE: MDR Tracking #: M5-03-2943-01
IRO Certificate #: IRO4326

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___'s health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History
This patient sustained an injury on ___ while lifting several heavy boxes. She reported pain and a burning to her lower back, radiating down her right lower extremity. She began seeing a chiropractor for therapy. A lumbar MRI dated 10/16/00 revealed mild stenosis and a small disc protrusion with no effect on nerve roots. Lumbar x-rays showed spondylosis changes throughout the lumbar spine. She received bilateral median nerve branch blocks and bilateral radio frequency facet denervation.

Requested Service(s)
Office visits, aquatic therapy, massage, physical therapy, and electrical stimulation from 08/06/02 through 08/13/02

Decision
It is determined that the office visits, aquatic therapy, massage, physical therapy, and electrical stimulation from 08/06/02 through 08/13/02 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision
This interim assessment report on 08/06/02 explains the patient's current subjective complaints, reviews the present and past medical history, medications, objective findings, current status, treatment plan, treatment schedule, and treatment rationale. Nothing in this interim report specifically links this exacerbation of 08/06/02 with her original injury of ___.

Given the nature and extent of her injury and the minimal diagnostic test results, this patient's on the job injury should have previously resolved with the prior treatment. No further treatment would be medically necessary. There are no national guidelines that allow for continued treatment of this condition, especially almost ___ years after the original injury. Therefore, it is determined that the office visits, aquatic therapy, massage, physical therapy, and electrical stimulation from 08/06/02 through 08/13/02 were not medically necessary.

Sincerely,