MDR Tracking Number: M5-03-2978-01

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 July 17, 2003.

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 physical therapy was 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 treatment physical therapy was not found to be medically necessary, reimbursement for dates of service from 9/11/02 through 12/18/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 12th day of September 2003.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

September 10, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-2978-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and

written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel. This ___ reviewer has been certified for at least level I of the TWCC ADL requirements The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 21 year-old male who sustained a work related injury on ___. The patient reported that while at work he fell off a ladder, landed on his head and injuring his low back, neck and both wrists. The patient was evaluated at an emergency room where he underwent X-Rays of the cervical and lower spine, pelvis, forearm and wrist. The patient sustained a fractured right wrist and forearm. Initial diagnoses for this patient included fracture of the right wrist, cervical spine sprain/strain, myospasms/ lumbar sprain/strain, concussion, left wrist sprain/strain and right knee sprain/strain. The treatment for this patient included casting of the right wrist, passive therapies consisting of interferential heat/ice, ultrasound, soft tissue mobilization, physical therapy, work conditioning and work hardening.

Requested Services

Physical therapy from 9/11/02 through 12/18/02.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is upheld.

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a 21 year-old male who sustained a work related injury to his low back, neck and both wrists on ___. The ___ chiropractor reviewer also noted that the diagnoses for this patient included right wrist fracture, cervical spine sprain/strain, myospasms/lumbar sprain/strain, concussion, left wrist sprain/strain and right knee sprain/strain. The ___ chiropractor reviewer further noted that the treatment for this patient included casting of the right wrist, passive therapies consisting of interferential heat/ice, ultrasound, soft tissue mobilization, physical therapy, work conditioning and work hardening. The ___ chiropractor reviewer indicated that the documentation provided did not demonstrate the patient was benefiting or showing progress with the amount of treatment rendered. Therefore, the ___ chiropractor consultant concluded that the physical therapy from 9/11/02 through 12/18/02 was not medically necessary to treat this patient's condition.

Sincerely,