MDR Tracking Number: M5-03-3050-01

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 7-24-03.

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, therapeutic exercises, therapeutic activities, electrical stimulation, and mechanical traction 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 2-17-03 through 3-28-03 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 1st day of October 2003.

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

September 23, 2003

Re: MDR #: M5-03-3050-01
IRO Certificate No.: IRO 5055

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Physical Medicine and Rehabilitation.

Clinical History:
On ___ this patient suffered an on-the-job injury to her neck, back and left shoulder. She underwent over 20 visits for physical therapy prior to the dates at issue.

Disputed Services:
Electrical stimulation, therapeutic exercises, therapeutic activities, mechanical traction, therapeutic activities and office visits from 02/17/03 through 03/28/03.

Decision:
The reviewer agrees with the determination of the insurance carrier. The services in question were not medically necessary in this case.

Rationale:
This patient had already had adequate physical therapy prior to the dates that are being questioned. Further physical therapy was unlikely to improve her status. On her Functional Capacity Evaluation, dated 03/06/03, she demonstrated a variety of tests not consistent with published population norms.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,