

MDR Tracking Number: M5-02-2591-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 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 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 rendered was not medically necessary.

Based on review of the disputed issues within the request, the Division has determined that the ___ rendered was the only fee involved in the medical dispute to be resolved. As the treatment, mri, was not found to be medically necessary, reimbursement for dates of service 8/4/01 through is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 16th day of August 2002.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and subsequently re-delegated by Virginia May, Deputy Executive Director.

August 16, 2002

Re: Medical Dispute Resolution
MDR #: M5-02-2591-01
IRO Certificate No.: IRO 5055

Dear

___ 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 board certified in Physical Medicine and Rehabilitation.

THE REVIEWER OF THIS CASE **AGREES** WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER. The reviewer has determined that additional physical therapy beyond the initial four weeks of therapy was **NOT** medically necessary in this case, specifically dates of 01.08.02, 01.10.02, 01.23.02, 01.24.02, 01.29.02, 01.31.12 and 02.06.02.

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.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted.

Sincerely,

MEDICAL CASE REVIEW

This is for ___. I have reviewed the medical information forwarded to me concerning TWCC Case File #M5-02-2591-01, in the area of Physical Medicine and Rehabilitation. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Request for review of denial of physical therapy on January 8, January 10, January 23, January 24, January 29, January 31, and February 6, 2002.
2. Correspondence from the requesting parties.
3. Peer review assessment by ___.
4. Progress notes from the physical therapy clinic.
5. Progress notes from the orthopedic surgeon, ___.

B. BRIEF CLINICAL HISTORY:

This is a 60-year-old lady who slipped and fell onto her back, sustaining ___ a possible injury to the cervical spine, lumbar spine, hip, and elbow. This was diagnosed as myofascial sprain/strains, greater trochanteric bursitis, and contusions. These multiple soft tissue lesions were treated conservatively with physical therapy, medications, and several weeks later with injections. She continued to complain of pain for more than six weeks with diffuse complaints and no specific overt objective pathology.

C. DISPUTED SERVICES:

As indicated in the records, a number of physical therapy CPT codes as noted on the Table of Services, all relative to separate modalities which were provided to this lady under the prescription of ___.

D. DECISION:

I AGREE WITH THE DETERMINATION OF THE INSURANCE CARRIER IN THIS CASE.

E. RATIONALE OR BASIS FOR DECISION:

Although there was a clear indication that there were ongoing symptoms after January 8th, based on the physical therapy progress notes, the modalities rendered--the stretching, moist heat, joint mobilization, and other modalities--could have easily been taught to this individual and she could have completed them with a comprehensive home exercise program. She additionally underwent a number of passive modalities for four weeks, and given the nature of the injury sustained, the contusions, and the bursitis, they should have essentially resolved within four to six weeks. At that time, the individual should have been instructed in a comprehensive home exercise program to allow for moist heat, Theraband stretching, joint mobilization, and other techniques to be completed at home. There was no clear indication for the physical therapy other than the complaints of a mild to moderate pain level (4/10) as noted in the progress notes provided by ___. Therefore, I do not think the additional physical therapy after the initial four weeks of therapy was required.

F. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

Date: 13 August 2002