THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER: SOAH DOCKET NO. 453-03-1638.M5

MDR Tracking Number: M5-02-3119-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent.

The IRO decision is the documentation supported the medical necessity of office visits and physical therapy for dates of service 4/1/02 through 4/26/02. All services after 4/26/02 were considered not medically necessary. The amount of payment due for the non-medically necessary services exceeded the amount of the services considered medically necessary. On this basis, the Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(q)(9), the Commission hereby **declines to order the respondent** to refund the requestor for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

Based on review of the disputed issues within the request, the Medical Review Division has determined **medical necessity was the only issue** to be resolved. The services prior to 4/26/02 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement.

This Order is hereby issued this 20th day of November 2002.

Noel L. Beavers
Medical Dispute Resolution Officer

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 4/1/02 through 4/26/02 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 20th day of November 2002.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/nlb

November 5, 2002

Rosalinda Lopez
Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-02-3119-01
IRO Certificate No.: IRO 5055

Dear Ms. Lopez:

___ 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 Chiropractic medicine.

Clinical History:
This 51-year-old male claimant injured his back on his job on ___. He has undergone diagnostic testing and a variety of treatments as follows: intensive physical therapy, chiropractic care, two full sets of epidural steroid injections, two-level IDET procedures, annuloplasty at L1-L2 and L4-L5, post-annuloplasty protocol physical therapy. The records indicate the patient may have participated in a work hardening program at one time, as well.

Following the initial four-week post-annuloplasty protocol, the patient's pain level was 2 on a scale of 1 to 10. There were no significant findings documented.

Disputed Services:
Office visits and physical therapy for the period 04/01/02 through 06/14/02.

Decision:
The reviewer partially agrees with the determination of the insurance carrier. The reviewer is of the opinion that the office visits and physical therapy for the period 04/01/02 through 04/26/02 were medically necessary. The services rendered after 04/26/02 were not medically necessary in this case.

Rationale for Decision:
Given the fact that the patient's pain level was 2 on a scale from 1 to 10, and there were no significant objective findings documented, additional post-annuloplasty protocol beyond 04/26/02 was not reasonable, customary or medically necessary.

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,