

MDR Tracking Number: M5-04-0973-01

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 December 3, 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 therapeutic procedures, kinetic activities, physical medicine treatment, joint mobilization, and office visits 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 Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the treatments listed above were not found to be medically necessary, reimbursement for dates of service from 02-10-03 to 03-07-03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 20th day of February 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division
PR/pr

February 17, 2004

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

Re: MDR #: M5-04-0973-01
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.

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.

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 Pain Management.

REVIEWER'S REPORT

Clinical History:

This claimant suffered extensor tendon laceration in a job-related accident on _____. After tendon repair performed in office on that same day, convalescence was accomplished followed by recommendation of physical therapy for the second digits.

Disputed Services:

Therapeutic procedures, kinetic activities, physical medicine treatment, joint mobilization, and office visit during the period of 02/10/03 thru 03/07/03.

Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were not medically necessary in this case.

Rationale:

The period of physical therapy outlined in this case is excessive. It is opined by _____ that the claimant in this case would have been unable to progress exercises independently, and the possibility of a re-injury during an independent program were of concern. There is no reason to suggest that this claimant could not have accomplished a safe and independent unsupervised program after having spent 8 weeks previously in a supervised setting. Further, there is no guarantee that re-injury could be avoided in a supervised program.

Sincerely,