

MDR Tracking Number: M5-04-1228-01

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 12-29-03.

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 physical performance test 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 Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the service listed above was not found to be medically necessary, reimbursement for date of service 6/27/03 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 29<sup>th</sup> day of March.

Regina L. Cleave  
Medical Dispute Resolution Officer  
Medical Review Division

RLC/rlc

#### NOTICE OF INDEPENDENT REVIEW DECISION

March 17, 2004

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IRO Certificate #: IRO4326

The \_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to \_\_\_ for independent review in accordance with TWCC §133.308 which allows for medical dispute resolution by an IRO.

\_\_\_ has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a \_\_\_ physician reviewer who is board certified in family practice which is the same specialty as the treating physician. The \_\_\_ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to \_\_\_ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

#### Clinical History

This patient sustained an injury on \_\_\_ while pulling a cart which fell over. She complained of neck and back pain, with radiating paresthesias in both upper and lower extremities. Conservative treatments have consisted of physical therapy, chiropractic treatment, epidural steroid injections, and analgesic, muscle relaxant, and anti-depressant medications.

#### Requested Service(s)

Physical performance test on 06/27/03

#### Decision

It is determined that the physical performance test on 06/27/03 was not medically necessary to treat this patient's condition.

#### Rationale/Basis for Decision

As per prior evaluations, this patient did not have herniated nucleus pulposus only spasms to her back. Lumbar pain exacerbations are most likely precipitated by psychological and economical issues notated in the documentation. Therefore, it is determined that the physical performance test on 06/27/03 was not medically necessary.

Sincerely,