

MDR Tracking Number: M5-05-0511-01

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 10-12-04.

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 ultrasound, electrical stimulation, massage therapy, therapeutic exercises, manual therapy technique, patient re-evaluation and therapeutic activities 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 medical necessity 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 11-03-03 to 01-16-04 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Findings and Decision is hereby issued this 10th day of January 2005.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

Enclosure: IRO decision

NOTICE OF INDEPENDENT REVIEW DECISION

January 5, 2005

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking #: M5-05-0511-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) 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 TMF for independent review in accordance with TWCC §133.308 which allows for medical dispute resolution by an IRO.

TMF 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 TMF physician reviewer who is board certified in Orthopedic Surgery which is the same specialty as the treating physician, provides health care to injured workers, and licensed by the Texas State Board of Medical Examiners in 1969. The TMF 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 TMF 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 male patient injured his right ankle, elbow and wrist on ____ when he fell off a 10-foot ladder onto his right side. The result was a fractured right ankle and sprain/strain blunt trauma to the right elbow and wrist. He has been treated with therapy.

Requested Service(s)

Ultrasound, electrical stimulation, massage therapy, therapeutic exercises, manual therapy technique, patient re-evaluation and therapeutic activities for dates of service 11/03/03 through 11/16/03, 11/26/03 and 12/03/03 through 01/16/04. Dates of service 11/21/03 and 12/01/03 not reviewed.

Decision

It is determined that there is no medical necessity for the ultrasound, electrical stimulation, massage therapy, therapeutic exercises, manual therapy technique, patient re-evaluation and therapeutic activities for dates of service 11/03/03 through 11/16/03, 11/26/03 and 12/03/03 through 01/16/04. Dates of service 11/21/03 and 12/01/03 were not reviewed.

Rationale/Basis for Decision

Medical record documentation did not indicate the reason for the therapy provided, specific documentation that an injury was present or the reason for the extensive physical therapy that was regularly provided to this patient. The physical therapies listed are not considered medically necessary without this medical documentation. Therefore, the ultrasound, electrical stimulation, massage therapy, therapeutic exercises, manual therapy technique, patient re-evaluation and therapeutic activities for dates of service 10/03/03 through 11/16/03, 11/26/03 and 12/03/03 through 01/16/04 were not medically necessary to treat this patient's medical condition. (Dates of service 11/21/03 and 12/01/03 were not reviewed.)

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:dm
Attachment

Information Submitted to TMF for TWCC Review

Patient Name:

TWCC ID #: M5-05-0511-01

Information Submitted by Requestor:

- Office Notes
- Daily Treatment Records
- Claims

Information Submitted by Respondent: