

MDR Tracking Number: M5-03-1782-01

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 Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(q)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$650.00** 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.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The physical therapy treatments were found to be medically necessary. The respondent raised no other reasons for denying reimbursement of the physical therapy treatments.

This Decision is hereby issued this 13<sup>th</sup> day of June 2003.

Margaret Q. Ojeda  
Medical Dispute Resolution Officer  
Medical Review Division

MQO/mqo

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 4/4/02 through 6/7/02.

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 13<sup>th</sup> day of June 2003.

David R. Martinez, Manager  
Medical Dispute Resolution  
Medical Review Division

MQO/drm

June 5, 2003

## NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M5-03-1782-01  
IRO Certificate #: 5348**

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). \_\_\_ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to \_\_\_ for independent review in accordance with this Rule.

\_\_\_ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the \_\_\_ external review panel. This physician is board certified in physical medicine and rehabilitation. The \_\_\_ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to \_\_\_ for independent review. In addition, the \_\_\_ physician reviewer certified that the review was performed without bias for or against any party in this case.

### Clinical History

This case concerns a 24 year-old male who sustained a work related injury on \_\_\_. The patient reported that while at work he was in his truck at a red light when he was rear-ended by another truck. The patient underwent X-Rays and an MRI. The diagnoses for this patient included cervical strain and mechanical low back pain. The patient was initially treated with three weeks of physical therapy but did not benefit from this. The patient then transferred his care and was treated with eight weeks of rehabilitation and 6 weeks of work hardening. This patient received 6 weeks of rehabilitation from 4/4/02 through 5/24/02 and three weeks of work hardening from 5/28/02 through 6/14/02. Prior to 4/4/02 he had received 3 weeks of physical therapy following his motor vehicle accident on 2/11/02. This therapy mainly consisted of modalities.

### Requested Services

Physical therapy treatments and services rendered from 04/04/02 through 06/07/02.

### Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

### Rationale/Basis for Decision

The \_\_\_ chiropractor reviewer noted that this case concerns a 24 year-old male who started two courses of physical therapy and rehabilitation on 4/4/02. The \_\_\_ physician reviewer also noted that at that time the patient complained of pain rating a 5/10, decreased range of motion in the lumbar spine, decreased motion in the cervical spine and was unable to climb or lift over twenty pounds. The \_\_\_ physician reviewer indicated that the patient received exercise programs and had improvement. The \_\_\_ physician reviewer explained that by 5/24/02 the patient was felt to be ready for a work hardening program and received this type of program from 5/28/02 through 6/14/02 with good improvement. The \_\_\_ physician reviewer noted that the patient's work capacity improved to "heavy physical" (required for his job) from "light, medium capacity". The \_\_\_ physician reviewer explained that the patient had full cervical and lumbar range of motion and a 0/10 pain rating. The \_\_\_ physician reviewer also explained that the second course of active physical therapy and work hardening program were appropriate and medically necessary. The \_\_\_ physician reviewer further explained that this patient achieved good functional improvement. Therefore the \_\_\_ physician consultant concluded that the physical therapy treatments and services rendered from 4/4/02 through 6/7/02 were medically necessary to treat this patient's condition.

Sincerely,