

MDR Tracking Number: M5-03-2718-01

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 6-24-03.

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(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** 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 requestor withdrew the date of service (10-7-02) that was denied per the *Medical Fee Guideline*. The therapeutic exercises, office visits, joint mobilization, myofascial release, manual traction, range of motion, FCE, and work hardening program were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

The above Findings and Decision are hereby issued this 17th day of September 2003.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

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 12-2-02 through 2-19-03 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 17th day of September 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

August 27, 2003

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
4000 South IH-35, MS 48
Austin, TX 78704-7491

RE: MDR Tracking # M5-03-2718-01
IRO Certificate # IRO 4326

___ 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 Rule §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 matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___ health care professional 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 when he slipped and fell from a 3-foot counter on ___. He had injuries to his neck and back and saw a chiropractor for treatment and physical therapy. An MRI dated 10/16/02 revealed a disc herniation at C3-4, C5-6, and C6-7, all with dural sac deformity and lateral canal stenosis. The nerve conduction velocity study of the upper extremity from 10/30/02 suggests left C7 nerve root or sensory pathway dysfunction.

Requested Service(s)

Therapeutic procedure, office visits, myofascial release, joint mobilization, manual traction, unusual travel, range of motion testing, data analysis, functional capacity evaluation, work hardening, and team conference from 12/02/02 through 02/07/03 and 02/13/03 through 02/19/03

Decision

It is determined that the therapeutic procedure, office visits, myofascial release, joint mobilization, manual traction, unusual travel, range of motion testing, data analysis, functional capacity evaluation, work hardening, and team conference from 12/02/02 through 02/07/03 and 02/13/03 through 02/19/03 were medically necessary to treat this patient's condition.

Rationale/Basis for Decision

Review of the provided medical record shows that this patient sustained disk related injuries from his work related accident on _____. It is clear from review of the medical file that the sustained injuries created functional impairments that were treated from 12/02/02 through 02/19/03. The treatment that was activated by the provider was appropriate for the patient's medical condition.

It is clear from the medical record that the provider was attempting to activate active therapeutics with this patient as early as 12/02/02. The provider implemented appropriate diagnostic testing that included MRI and electromyography and nerve conduction velocity (NCV) and somatosensory evoked potential (SSEP) in an acceptable timeframe. The patient was moved into a return-to-work program like work hardening after being qualified with necessitated functional baseline testing on 01/15/03. The functional capacity evaluation (FCE) on 01/15/03 shows deficits of function that would have been best treated in the multidisciplinary treatment format established in a work hardening program. The FCE performed on 03/03/03 shows a notable improvement in the patient's Physical Demand Level (PDL).

It is clear from the FCE that the patient had a deficit of function. The provider implemented necessitated testing and documented a baseline of function that warranted the application of therapies designed to return the patient to industry; therapies that included work hardening. Therefore, it is determined that the therapeutic procedure, office visits, myofascial release, joint mobilization, manual traction, unusual travel, range of motion testing, data analysis, functional capacity evaluation, work hardening, and team conference from 12/02/02 through 02/07/03 and 02/13/03 through 02/19/03 were medically necessary to treat this patient's condition.

The aforementioned information has been taken from the following guidelines of clinical practice and clinical references:

- Jordan A. Ostergaard, K. Rehabilitation of neck/shoulder patients in primary health care clinics. *J Manipulative Physiol Ther.* 1996 Jan;19(1):32-35.
- Kankaanpaa M, Taimela S, Airaksinen O. *The efficacy of active rehabilitation in chronic low back pain. Effect on pain intensity, self-experienced disability, and lumbar fatigability.* *Spine.* 1999 May 15;24(10):1034-42.
- Wright A, Mayer TGT, Gatchel RJ. *Outcomes of disabling cervical spine disorders in compensation injuries. A prospective comparison to tertiary rehabilitation response for chronic lumbar spinal disorders.* *Spine* 1999 Jan 15; 24(2): 178-83.

Sincerely,