MDR Tracking Number: M5-03-3185-01

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 August 5, 2003.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. 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 was the only issue** to be resolved. The therapeutic exercises, neuromuscular re-education, therapeutic activities, massage therapy, electrical stimulation, whirlpool therapy, office visits, aquatic therapy, joint mobilization, and group health education from 12/19/02 through 2/18/03 were found to be medically necessary. The therapeutic exercises, neuromuscular re-education, therapeutic activities, massage therapy, electrical stimulation, whirlpool therapy, office visits, aquatic therapy, joint mobilization, and group health education from 2/20/03 through 3/13/03 were not found to be medically necessary. The respondent raised no other reasons for denying reimbursement of the therapeutic exercises, neuromuscular re-education, therapeutic activities, massage therapy, electrical stimulation, whirlpool therapy, office visits, aquatic therapy, joint mobilization, and group health education charges.

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 12/19/02 through 2/18/03 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 Decision is hereby issued this 16th day of October 2003.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division
MQO/mqo

October 14, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-3185-01

___ 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. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in occupational medicine, preventive medicine and public health. 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 32 year-old male who sustained a work related injury on ___. The patient reported that while at work he was hit by a 1200lb. beam that struck him on the head. The patient reported that he fell backwards and landed on his back. The patient was transported to the hospital where he was admitted and released on 10/23/02. On 10/28/02 the patient was evaluated and began treatment that included ultrasound, massage, hot pack, electrical stimulation, therapeutic exercises and instruction on a home program. The diagnoses for this patient included cervical, thoracic and lumbar strains.

Requested Services

Therapeutic exercises, neuromuscular reeducation, therapeutic activities, massage therapy, electrical stimulation, whirlpool therapy, office visits, aquatic therapy, joint mobilization and group health education from 12/19/02 through 3/13/03.

Decision

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

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 32 year-old male who sustained a work related injury to his head and back on ___. The ___ physician reviewer also noted that the patient was transferred to the hospital where he was admitted and released on 10/23/02. The ___ physician reviewer further noted that the diagnoses for this patient have included cervical, thoracic and lumbar strains. The ___ physician reviewer indicated that the treatment for this patient's condition has included ultrasound, massage, hot packs, electrical stimulation, therapeutic exercises and instruction on a home program. The ___ physician reviewer explained that minimal to no progress was reported by the treating physician. The ___ physician reviewer also indicated that after two months, the treatment should have been discontinued and other

modalities tried. The ___ physician reviewer explained that the range of motion goals set by physical therapy were not monitored closely and when reported, did not show marked change. The ___ physician reviewer also explained that there was little functional gain noted overall. Therefore, the ___ physician consultant concluded that the therapeutic exercises, neuromuscular reeducation, therapeutic activities, massage therapy, electrical stimulation, whirlpool therapy, office visits, aquatic therapy, joint mobilization and group health education from 12/19/02 through 2/18/03 were medically necessary to treat this patient's condition. However, the ___ physician consultant also concluded that the therapeutic exercises, neuromuscular reeducation, therapeutic activities, massage therapy, electrical stimulation, whirlpool therapy, office visits, aquatic therapy, joint mobilization and group health education from 2/20/03 through 3/13/03 were not medically necessary to treat this patient's condition.

Sincerely,