

MDR Tracking Number: M5-02-2819-01

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 IRO determined the disputed physical therapy services from 3/7/02 through 3/15/02 were not medically necessary. The Medical Review Division has reviewed the IRO decision and determined that **the respondent prevailed** on the issues of medical necessity. Therefore in accordance with §133.308(q)(9), the Commission hereby **Declines to Order** the respondent to reimburse the **requestor** for the paid 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 disputed physical therapy services were found to **not** be medically necessary. The respondent raised no other reasons for denying reimbursement for these services.

This Decision is applicable to dates of service 3/7/02 through 3/15/02 in this dispute.

This Decision is hereby issued this 15th day of November 2002.

Noel L. Beavers
Medical Dispute Resolution Officer
Medical Review Division

NLB/nlb

NOTICE OF INDEPENDENT REVIEW DECISION

October 4, 2002

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

RE: MDR Tracking #: M5-02-2819-01
IRO Certificate #: 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 §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 neurology 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 32 year old male sustained a work related injury on ___ when he was assembling an overhead fuel tank and hurt his neck and back. The patient underwent a cervical decompression and fusion in November of 2001 and physical therapy treatments from 03/07/02 through 03/15/02.

Requested Service(s)

Physical therapy treatments from 03/07/02 through 03/15/02 in the form of:
CPT code 97112 – Neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture and proprioception, CPT code 97124 – Massage, CPT code 07032 – Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes, and CPT code 97713 – Aquatic therapy with therapeutic exercises.

Decision

It is determined that the CPT code 97112 – Neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture and proprioception, CPT code 97124 – Massage, CPT code 07032 – Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes, and CPT code 97713 – Aquatic therapy with therapeutic exercises provided from 03/07/02 through 03/15/02 were not medically indicated to treat this patient's condition.

Rationale/Basis for Decision

This patient was intact neurologically and orthopedically prior to the surgical procedure. The surgical procedure was performed because of chronic neck, suboccipital and shoulder pain which was refractory to conservative treatment. After the anterior cervical decompression and fusion performed in November of 2001, the patient remained neurologically intact. Following this procedure, the patient should have been essentially symptom free and ready for sedentary work within three weeks postoperatively. At the sixth postoperative week, the patient should have been capable of moderate physical

activity and work. Heavy work, involving bending, stooping, lifting and overhead work should have been delayed until the 12th postoperative week when complete arthrodesis should have occurred. One on one physical therapy or modality treatment should not be necessary for the patient who does not have neurological deficits before or after a cervical decompression and fusion. If the patient must resume an extremely heavy physical occupation, some consideration should be given to starting a work hardening program at approximately three weeks after surgery so that the progression of exercise, building of muscle tone and work place confidence can be achieved by the sixth or seventh post-operative week. Physical therapy four months post surgery is not indicated. Therefore it is determined that CPT code 97112 – Neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture and proprioception, CPT code 97124 – Massage, CPT code 07032 – Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes, and CPT code 97713 – Aquatic therapy with therapeutic exercises provided from 03/07/02 through 03/15/02 were not medically indicated.

Sincerely,