

MDR Tracking Number: M5-04-0863-01

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 November 20, 2003.

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 \$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 therapeutic exercises were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

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 12/12/02 through 01/24/03 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 3rd day of February 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

PR/pr

NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISED 1/30/04

MDR Tracking Number: M5-04-0863-01

IRO Certificate No.: 5259

January 27, 2004

An independent review of the above-referenced case has been completed by a medical physician board certified in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___ or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY

This is a 55-year-old case manager who was injured on ___. She was lifting a box of files weighing 65 pounds and developed severe neck, shoulder and midback pain. She had evaluation with Cervical MRI on December 27th 2002 and was found to have a broad-based protrusion at C-4/5 and extruded disk herniation at C-6/7. She was referred to physical therapy for aggressive conservative measures and received nerve root injections as well as EMG evaluations. She failed to improve with conservative measures and underwent surgical decompression by ___. She received routine postoperative physical therapy.

REQUESTED SERVICE (S)

Medical necessity of therapeutic exercises: dates of service of 12/12, 12/16, 12/17, 12/20/2002, 1/10, 1/22, 1/24/2003

DECISION

Disagree with carriers adverse determination, disagree that services were medically unnecessary.

RATIONALE/BASIS FOR DECISION

The carrier and provider were contacted to get clarification regarding reasons for denial of services and reasons for provision of services. The carrier failed to respond to inquiries. The charges were discussed with the provider, and the extensive documentation provided was reviewed regarding each of service dates and services provided.

There was no obvious indication for the carriers claims of unnecessary medical services based on the medical records reviewed. The mechanism of injury was clear, the complaints were clear, and the treatment was reasonable, appropriate and consistent with a standard to norms of care for conservative management of acute musculoskeletal strain injuries and for conservative management of cervical radicular syndrome. There are no specific guidelines indicating a limit of therapeutic exercises of more than an hour as being inappropriate. The most ever charged for this claimant was 1 1/2 hours per visit. It is recognized that the goal of conservative care is to maximize function and avoid additional care including surgical procedures. Therefore the records reflect that the care provided was reasonable, appropriate and focused on avoiding surgical procedures if possible.

This is consistent treatment for the region and type of injury noted and standard of care.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©)

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3)

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 28th day of January 2004.