

MDR Tracking Number: M5-04-2384-01

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 March 31, 2004.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the majority of 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. Four units of aquatic therapy from 12-22-03 through 01-08-04 and office visits from 10-23-03 through 01-08-04 **were** found to be medically necessary. The massage therapy and whirlpool from 10-23-03 through 01-08-03 and massage therapy, whirlpool, and aquatic therapy for 10-23-03 **were not** 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 10/23/03 through 01/08/04 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 June 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division
PR/pr

06/04/2004

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___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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 care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed chiropractor with a specialty in rehabilitation. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

CLINICAL HISTORY

___ was injured on ___. According to the documentation, he underwent a L4/5 fusion on 4/1/03. The records of his treatment between 4/1/03 and 10/20/03 are basically non-existent in the records submitted by the provider. The patient had an exacerbation on or about 10/21/03. He presented to ___ on 10/21/03 after a six-month absence from treatment. The reason for exacerbation is stated to be 'cold weather'. He had a replacement and reprogramming of his spinal column stimulator on 11/14/03 by ___ MD. The patient is diagnosed with post operative lumbar spinal surgery and lumbar disc displacement. The surgical staples were removed on 11/24/03. ___ notes indicate ___ recommended the patient for rehabilitation. On 12/16/03 ___ recommends 8 visits of aquatic therapy with massage. During the 12/22/03, 12/23/03, 12/29/03, 12/31/03, 01/05/2004, 01/07/2004 and 1/8/04 notes, it indicates that ___ performed chest deep running for 5 minutes and attained a total of five feet of running. Forward running in chest deep water for 5 minutes totaling 5 feet and sideways running for 5 minutes totaling 5 feet on each date of service was noted as well. On 1/9/04, ___ indicates the patient's pain scale to be a 2/10.

DISPUTED SERVICES

Disputed services include DOS 10/23/03, 12/22/03, 12/23/03, 12/29/03, 12/31/03, 01/05/2004, 01/07/2004 and 01/08/2004. Services on these dates of service include massage, office visits, aquatic therapy and whirlpool therapy.

DECISION

The reviewer agrees with the previous adverse determination regarding the massage therapy (97124) and whirlpool (97022). However, the reviewer disagrees in part with the previous adverse determination regarding aquatic therapy (97113) and the office visits 99212 & 99213). The reviewer recommends approval of four units of aquatic therapy instead of the performed six. The reviewer indicates that the office visit of 10/23/03 should be the only service allowed for that date of service due to an exacerbation.

BASIS FOR THE DECISION

The reviewer concurs that a reasonable amount of active therapy would be prudent after the surgical procedure on 11/14/03. However, the reviewer indicates that massage and whirlpool treatment are not active therapy and would not be prudent at this point in treatment. The reviewer based this opinion on the Medical Disability Advisor, Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters and Evidence Based Medical Guidelines.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, Inc, dba ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,