

MDR Tracking Number: M5-04-4063-01

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 7-28-04.

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** 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 neuromuscular re-education, myofascial release, group therapeutic procedures, aquatic therapy, therapeutic exercises, physical performance test, and manual therapy techniques rendered from 7/28/03 through 8/15/03 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed service.

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 Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c) 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 7/28/03 through 8/15/03 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 and Order is hereby issued this 1st day of November 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division

RLC/rlc

October 18, 2004

**NOTICE OF INDEPENDENT REVIEW DECISION
Amended Determination**

RE: MDR Tracking #: M5-04-4063-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
----- Case #:

----- has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ----- 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 physical medicine and rehabilitation and is familiar with the condition and treatment options at issue in this appeal. 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 female who sustained a work related injury on ----- . The patient reported that while at work she injured his back when he was carrying a battery. The patient was initially treated with conservative care consisting of physical therapy and subsequently underwent a lumbar fusion at the L4-5 level on 1/10/02. The diagnoses for this patient include L4-5 herniated disc with severe radiculopathy of the right lower extremity, and instability of L4 and L5. Postoperatively the patient was further treated with therapeutic procedures, therapeutic activities, myofascial release, neuromuscular reeducation and aquatic therapy. The patient had also participated in a work hardening/conditioning program.

Requested Services

Neuromuscular reeducation, myofascial release, therapeutic procedures-group, aquatic therapy, therapeutic exercises, FCE-physical performance test, and manual therapy technique from 7/28/03 – 8/15/03.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Physical Therapy Review 6/27/03
2. Letter from Valley Clinic 1/26/03
3. Operative Note 1/10/02
4. Progress Summaries 5/14/03 - 8/13/03
5. FCE 7/30/03

Documents Submitted by Respondent:

1. No documents Submitted

Decision

The Carrier's denial of authorization for the requested services is overturned.

Rationale/Basis for Decision

The ----- physician reviewer noted that this case concerns a female who sustained a work related injury to her low back on -----. The ----- physician reviewer indicated that the patient underwent a L4-5 fusion on 1/10/02. The ----- physician reviewer noted that the patient continued with complaints of back and right lower extremity pain with range of motion deficiencies in the lumbar spine and strength. The ----- physician reviewer also noted that the patient received extensive physical therapy. The ----- physician reviewer indicated that the patient was showing slow but steady gains in her lumbar spine range of motion and muscle strength. The ----- physician reviewer noted that as of 7/23/03 the patient still had mild limitations in range of motion and strength in the lumbar spine and that by 8/13/03 the patient had achieved expected range of motion in the lumbar spine and that she showed improvement in the flexor/extensor strength (close to 100% of goals initially set for this patient). The ----- physician reviewer indicated that the patient was ready for a work hardening program with the eventual goals of returning to work. The ----- physician reviewer explained that an FCE was medically necessary to establish specific deficits pertaining to this patient's work requirements for work hardening. The ----- physician reviewer also explained that the physical therapy treatments received from 7/28/03 through 8/15/03 were medically necessary because the patient showed continued improvement and had not plateaued. The ----- physician reviewer further explained without this treatment, the patient would not have been ready for a work hardening program. Therefore, the ----- physician consultant concluded that the Neuromuscular reeducation, myofascial release, therapeutic procedures-group, aquatic therapy, therapeutic exercises, FCE-physical performance test, and manual therapy technique from 7/28/03 – 8/15/03 were medically necessary to treat this patient's condition.

Sincerely,