

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 8-13-04. Per a letter dated 12-1-04 the requestor has withdrawn the office visits on 12-9-03, 12-16-03, 1-5-04 and 1-12-04.

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** 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 manual therapy from 12-9-03 through 12-16-03, the therapeutic procedures (group), therapeutic exercises, and copies as well as the office visits on 12-18-03, 1-6-04, and 1-14-04 were **found** to be medically necessary. The manual therapy after 12-16-03 **was not** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees from 12-9-03 through 1-14-04 as outlined above:

- in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c) and 134.202(c)(6);
- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order.

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 Findings and Decision and Order is hereby issued this 2<sup>nd</sup> day of December, 2004.

Donna Auby  
Medical Dispute Resolution Officer  
Medical Review Division

Enclosure: IRO decision

## NOTICE OF INDEPENDENT REVIEW DECISION

October 15, 2004

**Amended Letter 11/18/04**

Program Administrator  
Medical Review Division  
Texas Workers Compensation Commission  
7551 Metro Center Drive, Suite 100, MS 48  
Austin, TX 78744-1609

RE: Injured Worker:  
MDR Tracking #: M5-04-4211-01  
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) 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 TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF 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 matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. TMF's health care professional 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 TMF 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 25 year-old female injured her neck and left upper extremity on \_\_\_ when two cases of shampoo fell and struck her in the back of the head. Her diagnoses are chronic intractable cervicalgia and cervical radiculitis. She has been treated with therapy, medication and epidural steroid injections.

### Requested Service(s)

97140-manual therapy technique, 97150-therapeutic procedures, 97110-therapeutic procedures, 99080-copies and office visits for dates of services 12/09/03 through 01/14/04

## Decision

It is determined that the manual therapies after 12/16/03 were not medically necessary to treat this patient's condition. However, the therapeutic procedures (97150 and 97110), and copies for dates of service 12/09/03 through 01/14/04 as well as the office visits on 12/18/03, 01/06/04, and 01/14/04 were medically necessary to treat this patient's medical condition.

## Rationale/Basis for Decision

Medical record documentation does not indicate the necessity for the manual therapy after 12/16/03, as there was no objective or subjective documentation to indicate that the therapy was effective in the management of the patient's injury. However the office visits on 12/18/03, 01/06/04, and 01/14/04 were medically necessary to treat and evaluate the patient's progress and condition.

The therapeutic procedures were medically necessary to treat this patient's medical condition. The Philadelphia Panel<sup>1</sup> indicated that for neck pain, therapeutic exercises were the only intervention with clinically important benefit. For several interventions and indications (e.g. thermotherapy, therapeutic ultrasound, massage, electrical stimulation), there was a lack of evidence regarding efficacy.

Sincerely,

Gordon B. Strom, Jr., MD  
Director of Medical Assessment

GBS:vn

Attachment

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<sup>1</sup> Philadelphia Panel Evidence-Based Guidelines on Selected Rehabilitation Interventions for Neck Pain. Phys Ther. 2001;81:1701-1717

## Information Submitted to TMF for TWCC Review

**Patient Name:**

**TWCC ID #: M5-04-4211-01**

### **Information Submitted by Requestor:**

- Letter of Dispute
- History and Physical
- Operative Report
- Consult
- Magnetic Resonance Imaging
- Range of Motion Test

### **Information Submitted by Respondent:**

- Progress Notes
- Independent Review
- Hospital Record
- Range of Motion Test
- Electromyogram/Nerve Conduction Velocity
- Xray/Magnetic Resonance Imaging
- Operative Report
- Consult
- Designated Doctor Evaluation
- Disputed Impairment Rating
- Physical Therapy Notes