

MDR Tracking Number: M5-05-0020-01

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 August 30, 2004.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the majority of the medical necessity issues. 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 FCE on 12/30/03 and 2/23/04, massage, therapeutic exercises, neuromuscular re-education, therapeutic activities from 1/6/04 through 2/20/04 were **not found to be medically necessary**. The massage, therapeutic exercises, neuromuscular re-education, therapeutic activities, and exercise equipment from 12/17/03 through 1/6/04 **were found to be medically necessary**. The respondent raised no other reasons for denying reimbursement of the work hardening program.

#### ORDER

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 12/17/03 through 1/6/04 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 1<sup>st</sup> day of November 2004.

Margaret Q. Ojeda  
Medical Dispute Resolution Officer  
Medical Review Division

MQO/mqo

Enclosure: IRO decision

October 27, 2004

## NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M5-05-0020-01**  
**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 diagnoses for this patient's condition has included right carpal tunnel syndrome, resolved, tendonitis right upper extremity, and cervical and thoracic sprain/strain. Treatment for this patient's condition has included physical therapy consisting of exercise, stretches, myofascial release, deep tissue massage, moist heat and electrical stimulation.

### Requested Services

Massage 97124, therapeutic exercises 97110, neuromuscular reeducation 97112, physical performance test 97750, therapeutic activities 97530 and exercise equipment A9300 from 12/17/03 through 2/23/04.

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

*Documents Submitted by Requestor:*

1. Chiropractic Peer Review 11/20/03
2. Exercise Log 12/11/03 – 2/10/04
3. Daily Progress Notes 12/11/03 – 2/19/04
4. FCE 12/30/03, 2/23/04

*Documents Submitted by Respondent:*

1. No documents submitted

Decision

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

Rationale/Basis for Decision

The ----- physician reviewer noted that this case concerns a female who sustained a work related injury on -----. The ----- physician reviewer indicated that the patient had been diagnosed with right carpal tunnel/tendonitis and had been treated with physical therapy from 11/10/03 through 2/20/04. The ----- physician reviewer noted that the physical therapy consisted of myofascial release, trigger point massage, and strengthening exercises. The ----- physician reviewer indicated that during this treatment the patient's pain level varied from 2/10 to 6/10. The ----- physician reviewer explained that the physical therapy notes fail to demonstrate any clear-cut evidence or consistent decrease in pain or objective improvements (as measured by range of motion/strength) except for those on FCE. The ----- physician reviewer indicated that by 1/6/04 upon reevaluation there was no clear-cut progress demonstrated as pain level did not change significantly and there were no documented objective findings. The ----- physician reviewer noted that the patient was independent with a home exercise program. The ----- physician reviewer explained that there was no expectation for this patient to make any further significant improvement in a reasonable time. The ----- physician reviewer also explained that the FCE and multiple activities performed on 12/30/03 and 2/23/04 were not appropriate for this patient because this patient's work duties consisted of typing and answering telephones. Therefore, the ----- physician consultant concluded that the FCE on 12/30/03 and 2/23/04 and the massage 97124, therapeutic exercises 97110, neuromuscular reeducation 97112, and therapeutic activities 97530 from 1/6/04 through 2/20/04 were not medically necessary to treat this patient's condition. The ----- physician consultant further concluded that the massage 97124, therapeutic exercises 97110, neuromuscular reeducation 97112, therapeutic activities 97530 and exercise equipment A9300 from 12/17/03 through 1/6/04 were medically necessary to treat this patient's condition.

Sincerely,

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State Appeals Department