

MDR Tracking Number: M5-04-0050-01

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 8-31-04.

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 office visits, therapeutic procedures, neuromuscular re-education, manual therapy, and therapeutic activities from 9/03/03 through 1/21/04 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 9/03/03 through 1/21/04 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 Decision and Order is hereby issued this 10<sup>th</sup> day of November 2004.

Regina L. Cleave  
Medical Dispute Resolution Officer  
Medical Review Division

RLC/rlc

NOTICE OF INDEPENDENT REVIEW DECISION

November 4, 2004

Rosalinda Lopez  
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 #: M5-05-0050-01  
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 51 year-old female injured her low back on \_\_\_\_ when she lifted a large dog while working in an animal hospital. Her medical diagnosis is lumbar intervertebral disc disorder. She has been treated with medications, therapy, surgery and epidural steroid injections.

### Requested Service(s)

Office visits, therapeutic procedures, neuromuscular reeducation, manual therapy, and therapeutic activities for dates of service 09/03/03 through 01/21/04

### Decision

It is determined that the office visits, therapeutic procedures, neuromuscular reeducation, manual therapy, and therapeutic activities for dates of service 09/03/03 through 01/21/04 were medically necessary to treat this patient's medical condition.

### Rationale/Basis for Decision

National treatment guidelines allow for post-operative rehabilitation. The patient was seen on 09/03/03 for a re-evaluation and based upon the results of this exam, an aggressive post-operative rehabilitation program was started. There is sufficient subjective, as well as objective, findings documented on each date of denied services to clinically justify the medical necessity of those services. Therefore, the office visits, therapeutic procedures, neuromuscular reeducation, manual therapy, and therapeutic activities for dates of service 09/03/03 through 01/21/04 were medically necessary to treat this patient's medical condition.

Sincerely,