

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 1-19-05.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the Patient re-evaluation, aquatic therapy/exercises and therapeutic exercises denied as "U" were not medically necessary.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service are denied and the Medical Review Division declines to issue an Order in this dispute.

This Finding and Decision is hereby issued this 15<sup>th</sup> day of April 2005.

Donna Auby  
Medical Dispute Resolution Officer  
Medical Review Division

DA/da

Enclosure: IRO decision

#### NOTICE OF INDEPENDENT REVIEW DECISION

April 7, 2005

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 #: M5-05-1481-01  
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 33 year-old male injured his shoulder on \_\_\_\_ while lifting a heavy desk. He has been treated with medications, therapy and surgery.

#### Requested Service(s)

Patient re-evaluation, aquatic therapy/exercises, therapeutic exercises for dates of service 03/03/04 through 05/14/04

#### Decision

It is determined that there is no medical necessity for the patient re-evaluation, aquatic therapy/exercises, and therapeutic exercises for dates of service 03/03/04 through 05/14/04 to treat this patient's medical condition.

#### Rationale/Basis for Decision

Therapeutic exercises may be performed in a clinic one-on-one, in a clinic in a group, at a gym or at home with the least costly of these options being a home program. A home exercise program is also preferable because the patient can perform them on a daily basis. While, physical medicine is an accepted part of a rehabilitation program following an injury, services that do not require "hands-on care" or supervision of a health care provider are not considered medically necessary services even if a health care provider performs the services. In this case, there is no evidence to support the need for monitored therapy. Medical record documentation does not indicate why these services were required to be performed aquatically or one-on-one. Any gains obtained in this time period would have likely been achieved through performance of a home program. Therefore, the patient re-evaluation, aquatic therapy/exercises and therapeutic exercises for dates of service 03/03/04 through 05/14/04 were not medically necessary to treat this patient's medical condition.

Sincerely,



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

GBS:dm

Attachment

Information Submitted to TMF for TWCC Review

Patient Name:

TWCC ID #: M5-05-1481-01

Information Submitted by Requestor:

- Initial report
- Office notes
- Diagnostic Tests
- Work hardening
- Functional capacity evaluation
- Requests
- Claims

Information Submitted by Respondent: