

MDR Tracking #M5-05-1672-01

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 2-8-05.

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 therapeutic exercises, neuromuscular reeducation, manual therapy technique, therapeutic activities, and office visit from 2-9-04 through 8-9-04 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 4<sup>th</sup> day of May, 2005.

Medical Dispute Resolution Officer  
Medical Review Division

Enclosure: IRO decision

Parker Healthcare Management Organization, Inc.  
3719 North Belt Line Road, Irving, TX 75038  
972.906.0603 972.255.9712 (fax)

May 2, 2005

**ATTN: Program Administrator**  
**Texas Workers Compensation Commission**  
Medical Dispute Resolution, MS-48  
7551 Metro Center Drive, Suite 100  
Austin, TX 78744  
Delivered by fax: 512.804.4868

## Notice of Determination

IRO CASE NUMBER: M5-05-1672-01  
RE: Independent review for \_\_\_\_

The independent review for the patient named above has been completed.

- Parker Healthcare Management received notification of independent review on 3.8.05.
- Fax request for provider records made on 3.10.05.

- The case was assigned to a reviewer on 4.7.05.
- The reviewer rendered a determination on 4.28.05.
- The Notice of Determination was sent on 5.2.05.

The findings of the independent review are as follows:

## Summary of Clinical History

The patient, \_\_\_ was injured while performing her work related duties. Ms. \_\_\_ failed non-operative treatment after injury of \_\_\_. Subsequently, in 9/5/01, the patient had a lumbar hemilaminotomy with discectomy and L4- 5, right, foraminotomy at L4-5 and L5-S1 on the right. The patient initially did well after surgical intervention, however, had limited progress in rehab and continued complaints of low back and right posterior leg pain. The patient was treated with rehab and pain management, however, because of continued pain and failure to resolve, the patient and surgery on 6/11/03. This was a 360° L4-5 fusion with therapy beginning on 6/25/03. The patient continued formal therapy with gradual, though slow, improvement, also demonstrating an ability to perform a home exercise program, which was documented. Subsequently, the patient had removal of hardware on 6/9/04.

## Questions for Review

The reviewer was asked to review the following services: Dates of service 2/9/04 through 8/9/04, codes denied 97110 therapy exercises; 97112 neuromuscular reeducation; 97140 manual therapy technique; 97530 therapeutic activities; 99214 office visit-reviewed for medical necessity.

## Determination

The determination of the reviewer is to **uphold the denial** of the disputed care as it was not proven as medically necessary.

## Clinical Rationale

There are clinical guidelines from the American Academy of Orthopedic Surgeons and the North American Spine Society, which recommend physical therapy after a second surgical procedure for up to six months. It is also recognized that the patient may continue to have some pain after this period of time. It is well documented that the patient was continuing to improve in January, 2004. The patient had excellent range of motion and minor pain complaints and was able to participate in a well structured home exercise program and accomplish the goals of ADL. Even after the surgery to remove hardware, it is my opinion that the patient would have been able to resume her home exercise program and continue to progress without the necessity of a formal rehab program.

Therefore, based upon a review of the records, including the assessments of Dr. Kjeldgaard, the documented improvement in the patient's status and the fact that the patient demonstrated, very well, an ability to perform the recommendations of the therapy clinic and the fact that the patient demonstrated a willingness to do the exercises at home, it is my professional judgment and experience that the patient reached maximal physical therapy benefits by 2/9/04 and formal physical therapy beyond that, was not supported as reasonable or necessary.

## Clinical Criteria, Utilization Guidelines or other material referenced

American Academy of Orthopedic Surgeons, clinical guidelines  
North American Spine Society, clinical guidelines

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The reviewer for this case is a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer is a diplomat of the *American Board of Orthopedic Surgery*, and is engaged in the full time practice of medicine.

The review was performed in accordance with Texas Insurance Code §21.58C and the rules of the Texas Workers Compensation Commission. In accordance with the act and the rules, the reviewer is listed on the TWCC's list of approved providers, or has a temporary exemption. The review includes the determination and the clinical rationale to support the determination. Specific utilization review criteria or other treatment guidelines used in this review are referenced.

The reviewer signed a certification attesting that no known conflicts-of-interest exist between the reviewer and any of the providers or other parties associated with this case. The reviewer also attests that the review was performed without any bias for or against the patient, carrier, or other parties associated with this case.

A Copy of this determination was faxed to TWCC, Medical Dispute Resolution Department, who will submit copies to all other parties involved in this case.

If our organization can be of any further assistance, please feel free to contact me.

Sincerely,

Meredith Thomas  
Administrator