Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 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 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 office visits, physical therapy, unlisted therapeutic procedures, supplies and special report were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that office visits, physical therapy, unlisted therapeutic procedures, supplies and special report fees were the only fees involved in the medical dispute to be resolved. As the treatment was not found to be medically necessary, reimbursement for dates of service from 2/8/02 to 5/22/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 4th day of April 2003.

Noel L. Beavers
Medical Dispute Resolution Officer
Medical Review Division

NLB/nlb

NOTICE OF INDEPENDENT REVIEW DECISION

Date: April 1, 2003

Requester/ Respondent Address : Rosalinda Lopez
TWCC
4000 South IH-35, MS-48
Austin, Texas 78704-7491

RE: MDR Tracking #: M5-03-0483-01
IRO Certificate #: 5242

___ 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 ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed 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 Pain Management/Rehabilitation/Chiropractic physician reviewer who is board certified in Pain Management/Rehabilitation. The Pain Management/Rehabilitation/Chiropractic physician reviewer 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 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

Claimant is a now 63 year old female who is 5'2" in height with a weight of 230 pounds. She has a reported work injury date on ___ when she hit a stool with her right knee while working. She experienced immediate right knee pain, applied ice to area during that day and did have a large area of bruising per records. She was evaluated on 11-21-01 by a chiropractor for continued knee pain. In the past history he is stated she has another work injury still ongoing with treatment to the neck, mid back and low back areas. Time of treatment and date of that injury is not in the records. On exam she has normal extension of the right knee, decreased flexion. Some bruising is still present. X-ray of the knee is performed and showed decreased medial and lateral joint space, mild chondromalacia patella noted, no bony abnormalities. This would be degenerative changes only. Diagnosis is acute sprain/strain of the knee manifestations. Orders include: ultrasound, sterile whirlpool, spray and stretch, therapeutic massage, aquatic therapy and re-evaluate in 6 weeks.

1-15-02 note range of motion is to almost normal on this note at 130 degrees. Slowly improving per note. Orders for continued aquatic therapy, stretching exercises with supervision and re-evaluate in 4 to 5 weeks.

2-26-02 patient is now on Celebrex and this is helping. Doctor ordered this medication. Plans are for physical therapy modalities at 3 times a week for 4 weeks of whirlpool, aquatic therapy, stretching exercises, therapeutic phonophoresis cream. Note is signed by a chiropractor.

3-26-02 put to home exercise program, return as needed, by Chiropractor

MRI of the right knee dated 12-5-01, there appears to be a small area of bone bruising the intercondylar notch region of the distal femur; subchondral cyst or chondromalacia of the medial articular surface of the patellar; tear or injury to the medial collateral ligament; grade 2 degeneration of the posterior horn of the medial meniscus, complete tear is not identified; no other abnormality.

Physical therapy notes are present; 1-30-02 to 3-28-02 for 8 notes in total. Notes for daily treatment would be more than 8. No daily notes are with records. There is no signature present on any of these long, what appears, updated notes. I do not know who is generating this report.

Examination notes on 3-25, 3-27, 3-28-02 by MD are provided. These notes have little to no medical information presented, but more Texas law information. Notes are unchanged in the 3 exam dates. These almost daily examinations lack documentation as to justification as to what is happening with the patient.

Impairment rating on 7-2-02 by another chiropractor gives patient 8% whole person impairment rating.

Requested Service(s)

The medical necessity of the outpatient services render from 2-8-02 to 5-22-02.

Decision

The services rendered were not medically necessary

Rationale/Basis for Decision

It appears this patient suffered a right knee bruise with sprain/strain on ___. Medical necessity or treatment beyond 8 weeks from injury for this diagnosis is not appropriate and the extensive modalities of physical therapy are also not the standard of care for the injury diagnosed.

According to literature in the fields of Physical Medicine and Rehabilitation, Physical Therapy, Osteopathic Medicine and Chiropractic Medicine have all shown that modalities beyond 3 per session offer no additional medical benefit to the patient. Therefore, on physical therapy sessions only 3 modalities should be indicated by literature and guidelines.

US Department of Health and Human Services Guidelines for the Treatment of Acute Pain recommend 12 sessions or one month of conservative care with a maximum of 3 modalities per session. Justification must be present to continue conservative care. This justification was not found in the records received to have the lengthy, extensive course of modalities that have been provided. Sprain/strain injuries will heal within 6 to 8 weeks, with or without conservative care in most cases.

The patient did have pre-existing degenerative changes present on MRI prior to injury. She is obese as classified by BMI testing and this would add to knee degeneration and this would add to her limitations in joints along with her age. This treatment rendered beyond 2 months post-injury date is not reasonable based on the mechanism and magnitude of trauma and, in part, is related to pre-existing factors.

Therefore, by guidelines and literature, treatment from 2-8-02 would be not medically indicated in this patient. She should be on a home program, use over-the-counter medications of Aleve or Naproxen for any discomfort. Results from her knee bruise and sprain/strain would have resolved before the above dates.

This decision by the IRO is deemed to be a TWCC decision and order.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 1st day of April 2003.