MDR Tracking Number: M5-03-0502-01

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 aquatic therapy, therapeutic procedure, phonophoresis and phonophoresis supplies, office visits, physical medicine treatment, ultrasound therapy, unlisted modality, massage therapy and electrical stimulation 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 aquatic therapy, therapeutic procedure, phonophoresis and phonophoresis supplies, office visits, physical medicine treatment, ultrasound therapy, unlisted modality, massage therapy and electrical stimulation 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 5/20/02 to 8/30/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 22nd day of May 2003.

Noel L. Beavers
Medical Dispute Resolution Officer
Medical Review Division
NLB/nlb

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

May 20, 2003

Re: IRO Case # M5-03-0502

Texas Worker’s Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker’s Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier’s internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Orthopedic Surgery. He or she has signed a certification statement attesting 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 referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

History
The patient is a 61-year-old lady who reportedly suffered cumulative trauma to multiple extremities as a result of many years working for a school food service. She initially complained of multiple arthralgias with bilateral wrist pain, left shoulder pain, bilateral knee pain, left hip/back pain, bilateral ankle pain. Since her initial evaluation, the patient has undergone surgery on both of her wrists, both of her knees, and her left shoulder. The patient underwentb ilateral trapezium arthroplasties and carpal tunnel releases; left shoulder arthroscopy with debridement of SLAP lesion and subscromial decompression; bilateral knee arthroscopies with debridement of severe chondromalacia. On 6/4/02, the patient underwent a right total knee arthroplasty. The patient has been treated by multiple orthopedic surgeons, and has also continued care with her chiropractor.

Requested Service
Aquatic therapy, therapeutic procedure, phonophoresis & unlisted modality, massage therapy, electrical stimulation 5/20/02-8/30/02

Decision
I agree with the carrier's decision to deny the requested treatment.

Rationale
The services in dispute would be considered unnecessary and excessive. There is no evidence that aquatic therapy was ordered by the treating orthopedic surgeons. The repeated chiropractic evaluations on such a frequent basis is excessive. The computerized notes from the chiropractor are lengthy, repetitive, and have no clear objective. During the treatment time in dispute, physical therapy by an accredited physical therapist three times per week would be the standard of care. Physical therapy with range of motion and strengthening was order for three times per week by her orthopedic surgeon 8/23/02.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

Sincerely,