THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-03-3328.M5

MDR Tracking Number: M5-03-0554-01

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 requestor submitted a medical dispute resolution request on 10/17/02 and was received in the Medical Dispute Resolution on 10/17/02. The disputed dates of service 8/28/01 through 10/16/01 are not within the one year jurisdiction in accordance with Rule 133.308(e)(1) and will be excluded from this Finding and Decision.

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 the office visits, physical therapies (including application of modality, electrical stimulation, myofascial release, ionophoresis), FCE and reports 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 therapies, FCE and 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 10/17/01 to 1/8/02 is denied and the Division declines to issue an Order in this dispute.

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

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

NOTICE OF INDEPENDENT REVIEW DECISION

January 24, 2003

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
4000 South IH-35, MS 48
Austin, TX 78704-7491

RE: MDR Tracking #: M5-03-0554-01
IRO Certificate #: 4326

___ 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 §133.308 which allows for medical dispute resolution by an IRO.

___ 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 ___ physician reviewer who is board certified in family practice which is the same specialty as the treating physician. The _____ 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

This 50 year old female sustained a work-related injury on ___ when she slipped, twisting her right knee and injuring her neck, right shoulder, leg, and lower back. An MRI of the right knee revealed a medical meniscus tear and the patient underwent an arthroscopy of the right knee on 04/11/01. The patient also underwent trigger point injections for cervical pain and interarticular joint injection to the right shoulder.

Requested Service(s)

Application of a modality, electrical stimulation, myofascial release, iotophoresis, special reports, office visits and functional capacity evaluation provided from 10/17/01 through 01/08/02.

Decision

It is determined that the application of a modality, electrical stimulation, myofascial release, iotophoresis, special reports, office visits and functional capacity evaluation provided from 10/17/01 through 01/08/02 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The patient underwent arthroscopic surgery for her knee and the medical record documentation indicates that the patient was released to return to work with no limitations by 06/04/01. An MRI of the right shoulder was negative for a rotator cuff tear and an examination of the patient's knee indicated that it was stable. Therefore, the services provided after 10/16/01 in the form of application of a modality, electrical stimulation, myofascial release, iotophoresis, special reports, office visits and functional capacity evaluation provided from 10/17/01 through 01/08/02 were not medically necessary.

Sincerely,