MDR Tracking Number: M5-03-1337-01

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 (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 1/30/03.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

The requestor withdrew the office visits of 3/22/02 and 4/19/02, the unusual travel of 2/26/02, 2/28/02, 3/1/02, 3/4/02, 3/5/02, 3/6/02, 3/7/02, 3/8/02, 3/11/02 and 3/12/02, the neuromuscular stimulator and DME of 2/25/02, neuromuscular stimulator of 3/22/02 and the myofascial release of 3/28/02 and 4/2/02. These services were disputed on the basis of the Commission's Medical Fee Guideline. Therefore, the Medical Review Division determines that **medical necessity was the only issue** to be resolved. The office visits (except for those coded 99215) and physical therapy from 2/26/02 through 4/5/02 were found to be medically necessary. All durable medical equipment from 2/26/02 through 5/6/02, all general supplies (E1399) from 2/26/02 through 5/6/02 and all office visits and physical therapy after 4/5/03 were found to be not medically necessary. The respondent raised no other reasons for denying reimbursement for the office visits, physical therapy, durable medical equipment and general supplies from 2/26/02 through 5/6/02.

This Finding and Decision is hereby issued this 12th day of September 2003.

Noel L. Beavers
Medical Dispute Resolution Officer
Medical Review Division

NLB/nlb

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due

at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 2/26/02 through 4/5/02 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 12th day of September 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/nlb

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

June 27, 2003

Re: IRO Case # M5-03-1337-01

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 Doctor of Chiropractic who is licensed by the State of Texas, and who also is a Certified Strength and Conditioning Specialist. 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 sprained his left ankle while playing basketball with children in his care on ___. He has had an MRI, CT and plain films.

Requested Service(s)
Office visits, physical therapy, DME, general supplies 2/26/02 – 5/6/02

Decision
I agree with the carrier's decision to deny all of the requested neuromuscular stimulator treatment, all of the office visits coded 99215, durable medical equipment coded E1399, myofascial release after 4/5/02.
I disagree with the carrier's decision to deny all other disputed treatment through 4/5/02.

Rationale
Treatment for this diagnosed left ankle sprain has exceeded $9,000. The patient has received 33 sessions of therapeutic exercises without documented relief of his symptoms. This is an excessive abuse of treatment protocol for a minor injury. The standard of care would include six weeks of treatment (2-26-02 through 4-5-02), and this type of sprain should have responded very well to treatment in six weeks. The documentation presented for this review fails to support the necessity for any treatment after 4/5/02.
Use of a neuromuscular stimulator was excessive for such a minor injury. The documentation does not show that this minor injury required detailed office visits coded 99215, the requested durable medical equipment, or myofascial release after 4/5/02. Treatment must be reasonable and effective in relieving symptoms or improving function, and the documentation failed to show how these services were necessary.

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

Sincerely,