MDR Tracking Number: M5-03-1453-01

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 office visits, range of motion, physical performance testing, and physical therapy 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 the medical necessity 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 5-3-02 through 9-30-02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 9th day of May 2003.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

DZT/dzt

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

April 20, 2003

Re: IRO Case # M5-03-1453

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 40-year-old female who was injured on ___. On 3/22/02 the patient was evaluated by an orthopedic surgeon, and on 4/2/02 the patient underwent left knee arthroscopy with lateral meniscectomy and extensive synovectomy. After surgery the patient was placed on a home exercise program, was referred for outpatient physical therapy three times a week, and was placed on Celebrex 200 mg per day. The patient returned to the treating D.C. on 5/3/02 for continued post op care. From 5/3/02 to 9/30/02, the patient underwent multiple evaluations by the D.C. as well as multiple manipulations, range of motion evaluations, muscle testing, myofascial releases, joint mobilizations and other "therapeutic procedures."

Requested Service
Office visits, range of motion, physical performance testing, physical therapy 5/3/02-9/30/02

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

Rationale
Based on the records provided for this review, in my opinion, the disputed care was not appropriate care after the patient underwent a left knee arthroscopy. Physical therapy and rehabilitation after knee arthroscopy is appropriate. The patient underwent a routine knee arthroscopy with lateral meniscectomy and synovectomy. Appropriate care following this procedure should include a home exercise program with occasional supervised visits with a physical therapist (two or three times per week for a few weeks), and follow up visits with the surgeon. Repeated chiropractic evaluations, manipulations, and repeated muscle testing is not appropriate. The post operative chiropractic care provided for this patient's left knee

was excessive and is not within the standard of care. In addition, the clinical notes and documentation provided by the treating chiropractor are vague and often repetitive. There is
no good clinical rationale given for the procedures and testing performed on the patient post
operatively.
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This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

Sincerely,

_____