THIS DECISION HAS BEEN APPEALED. THE FOLLOWING
IS THE RELATED SOAH DECISION NUMBER: 453-03-3680.M5

MDR Tracking Number: M5-03-1553-01

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 **or January 1, 2003** and Commission Rule 133.305 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent.

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.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The office visits and physical therapy sessions from 9-5-02 through 10-24-02 were found to be medically necessary. The FCE on 11-6-02 was not found to be medically necessary. The respondent raised no other reasons for denying reimbursement for these services.

The above Findings and Decision are hereby issued this 12th day of May 2003.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

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 9-5-02 through 11-6-02 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 May 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dzt

NOTICE OF INDEPENDENT REVIEW DECISION

Date: May 6, 2003

Requester/ Respondent Address :

TWCC
4000 South IH-35, MS-48
Austin, Texas 78704-7491

RE: MDR Tracking #: M5-03-1553-01
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 Chiropractic physician reviewer. The 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

According to the documentation supplied, it appears that the claimant was working at ___ on ___ he slipped while removing a motor out of a crane. The claimant reported that he heard a pop in his left knee. The claimant reported to ___ for an evaluation on 06/21/2001 and was seen by the chiropractor. The chiropractor originally diagnosed the claimant with lumbar, knee and ankle sprain. Chiropractic therapy was begun on the claimant. The claimant had a MRI performed on his left knee, right ankle and left ankle on 06/30/2001 which revealed a normal right and left ankle and a small tear of the posterior horn of the medical meniscus in his left knee. A MRI was performed on right knee and lumbar spine on 08/04/2001, which revealed a joint effusion mildly in his right knee. The MRI report stated that the claimant had a disc bulge at L4-5 and at L5-S1. The claimant had arthroscopy performed on his left knee on 08/24/2001 by the doctor. The claimant had surgery on his right knee on 03/18/2002 by the doctor. Then on 05/20/2002, the claimant had L5-S1 disc decompression, diskectomy, and fusion performed by a doctor. On 08/16/2002, the doctor prescribed physical therapy for the claimant for 8 weeks at 3 times a

week. Daily documentation was submitted for review from 09/05/2002 until 11/06/2002 with included reports. The documentation ends here.

Requested Service(s)

The medical necessity of the outpatient services including physical therapy, office visits, and functional capacity evaluations rendered between 09/05/2002 – 11/06/2002.

Decision

I disagree with the insurance company and agree with the treating doctor that the physical therapy was medically necessary 3 times a week from 09/05/2002 until 10/31/2002. I also feel that monthly office visits were medically necessary for proper referrals and re-exams. I agree with the insurance company that the physical therapy was not medically on 11/01/2002 and beyond. I also do not see the rationale for any functional capacity evaluations performed during this period as well.

Rationale/Basis for Decision

The claimant was post-surgery for a L5-S1 disc decompression, diskectomy and fusion. The surgeon who performed this task prescribed 8 weeks of physical therapy and strengthening program to continue the claimant's progress. It is in my opinion and that of current literature that postoperative rehabilitation is necessary for the continuation of care. Since the therapy that was performed at ___ was within this guideline, it is medically necessary. Any therapy beyond the initial 8 weeks is not necessary and should have transitioned the claimant to a home-based exercise program. With the large amount of therapy this claimant has already had, there would be minimal need for showing him new exercises. It is in my opinion that the functional capacity evaluations that were performed were not necessary. Since this claimant has had a significant amount of injuries and care, it would be best if an Independent Medical Examiner determined the amount of impairment/improvement.

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 6th day of May 2003.