

MDR Tracking Number: M5-03-1558-01

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, therapeutic exercises and activities, electrical stimulation, hot or cold packs and supplies 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, therapeutic exercises and activities, electrical stimulation, hot or cold packs and supply 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 6/17/02 to 7/30/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 9<sup>th</sup> day of May 2003.

Carol R. Lawrence  
Medical Dispute Resolution Officer  
Medical Review Division  
CRL/crl

#### NOTICE OF INDEPENDENT REVIEW DECISION

May 5, 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 #: M5-03-1558-01  
IRO Certificate #: IRO4326

\_\_\_ 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 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 orthopedic surgery 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 patient injured his left knee when he fell off a rack while at work on \_\_\_.

He had surgical repair of the affected knee on March 14, 2001. Post operatively, he was in a wheelchair for approximately 2 months and then used crutches with a leg brace. At this time, the patient still reported significant pain and weakness in his operative knee and was referred to physical therapy by his surgeon.

#### Requested Service(s)

Requested services were office visits, therapeutic exercises and activities, electrical stimulation, hot or cold packs, and special supplies used from 6/17/02 through 7/30/02.

#### Decision

It is determined that the office visits, therapeutic exercises and activities, electrical stimulation, hot or cold packs, and special supplies used from 6/17/02 through 7/30/02 were not medically necessary to treat this patient's condition.

#### Rationale/Basis for Decision

Based on the documentation provided, an intensive physical therapy regimen including modalities of hot/cold packs, electrical stimulation, whirlpool, and massage is not medically indicated. The justification for such an extensive physical therapy program would have to be present in the notes of the prescribing physician or surgeon. Without documentation from the physician and /or surgeon, no medical necessity can be established for this extensive and closely monitored physical therapy program.

Sincerely,