MDR Tracking Number: M5-03-1862-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 03-27-03. In accordance with Rule 133.307(d)(1) A dispute on a carrier shall be considered timely if it is filed with the division no later then one year after the dates of service in dispute therefore dates of service in dispute for 01-02-02 through 03-26-03 are considered untimely.

The IRO reviewed office visits with manipulations, therapeutic procedures, joint mobilization, and myofasical release rendered from 03-28-02 through 12-09-02 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity for office visits with manipulations, therapeutic procedures, joint mobilization, and myofasical release. Consequently, the requestor is not owed a refund of the paid IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On July 14, 2003, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice. The Medical Review Division is unable to review this dispute for fee issues. Documentation was not submitted in accordance with Rule 133.307(l) to confirm services were rendered for dates of service 04-22-02, 09-25-02, 10-22-02, 11-01-02, and 11-05-02. Therefore reimbursement is not recommended.

This Decision is hereby issued this 6th day of February of 2004.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

July 3, 2003

IRO Certificate# 5259
MDR Tracking Number: M5-03-1862-01

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___, or by the application of medical screening criteria and protocols formally established by practicing physicians.

All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY

The patient appears to have injured her right knee while performing work related duties ___. She underwent arthroscopic surgery with ___, and then was referred to ___ for post surgical rehabilitation. The patient failed to respond to conservative treatment and was then referred to another orthopedist, ___, for evaluation. MRI was performed 3/22/02 suggesting persisting anterior cruciate tear, effusion and generative joint disease. A second surgical opinion was obtained by a ___, suggesting ACL debridment, menisectomy, and chondroplasty. Over a period of approximately 9 months, this patient appears to have undergone as many as three knee surgeries and extensive pre and post-surgical chiropractic care, physical therapy, and rehabilitation with ___and his associates.

REQUESTED SERVICE (S)

Determine medical necessity for chiropractic services [joint mobilization, myofascial release, office visits w/manipulations, therapeutic procedures] rendered 3/28/02 through 12/9/02.

DECISION

Given the complicated nature of these orthopedic conditions, there does appear to be reasonable medical necessity for a great deal of treatment provided by ___and his associates. First, all chiropractic office visits designated 99213-MP signify E/M services with manipulation or mobilization as the primary management component. On multiple occasions this appears to be accompanied by 97265 mobilization and 97250 myofascial release therapies. The use of manipulation and mobilization concurrently with the diagnosis of meniscus and ACL tear would be considered clinically inappropriate and a duplication of the same or similar service. Medical necessity for these services is not supported by available documentation.

RATIONALE/BASIS FOR DECISION

TWCC Lower Extremity Guidelines and TWCC Rule 134.600. Accepted clinical standards for managing ACL and meniscal tears of the knee suggest significant contraindications to manipulation and mobilization procedures.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided.

It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials