MDR Tracking Number: M5-03-1868-01

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, manipulations, physical therapy, muscle testing, and FCE 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, manipulations, physical therapy, muscle testing, and FCE 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 9/16/02 to 1/15/03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 14th day of May 2003.

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

NOTICE OF INDEPENDENT REVIEW DECISION

Date: May 13, 2003

RE: MDR Tracking #: M5-03-1868-01
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

It appears the claimant suffered right ankle/foot injury when his foot struck a rail or wall while he was roller skating with some of his students on ___ as part of a field trip from a local school. The claimant appeared to be employed as a teacher at the time of the injury. The initial diagnosis at a local hospital was right ankle sprain. It was felt by the doctor that the claimant had some internal derangement of the right ankle. The claimant began seeing a chiropractor on or about 7/17/02. The claimant has also been diagnosed with tenosynovitis, tarsal tunnel syndrome and tear of the anterior talofibular ligament. The tear of the anterior talofibular ligament was diagnosed via the right ankle MRI and there was x-ray evidence of an avulsion fracture near the lateral malleolus. This would be suggestive of avulsion fracture. An MRI of the right foot showed no injury related findings. The claimant saw an osteopathic physician on 8/12/02 and his report was reviewed. There appeared to be no nerve/vascular compromise. There was no evidence of joint instability. The range of motion of the ankle was normal, but there was pain on end-range of motion. The claimant did not appear to want injections and he was given a Medrol Dosepak. The claimant saw another osteopathic physician for designated doctor purposes on 10/22/02 and was found to be at maximum medical improvement on that date with 0% whole person impairment rating. A voluntary certification for authorization of physical therapy was okayed for 3 times per week beyond 9/23/02. The claimant saw a doctor on 7/17/02 and his report is reviewed. Interestingly, the claimant was noted to be wearing an ankle support and was on crutches; however, the claimant's gait was reported as normal and the claimant's strength in the lower extremities was reported as normal. The right ankle exam by a doctor was extremely minimal and consisted of only one sentence in the report, yet one of the diagnoses were listed was "right lower extremity acroparesthesias, radiculitis, and weakness". This diagnosis is certainly not supported by the documentation from a doctor. A few functional abilities examinations of 7/18/02 and 9/6/02 are reviewed. There are multiple strength evaluations and range of motion evaluations which tend to range from 7/22/02 through 9/3/02.

Requested Service(s)

The medical necessity of the outpatient services including office visits, manipulations, physical therapy, muscle testing, and functional capacity evaluations from 9/16/02 through 1/15/03.

Decision

I agree with the insurance carrier that the chiropractic services in question including the office visits, manipulations, physical therapy, myofascial release, traction, muscle testing and various functional abilities evaluations and functional capacity evaluations were not reasonable or medically necessary.

Rationale/Basis for Decision

The documentation reveals the claimant has undergone chiropractic care and related physical therapy from about 7/17/02 through 1/15/03 and that by 9/3/02 the claimant's range of motion was 97% to 100% of normal at the ankle. The repeated strength testing through 8/14/02 revealed the claimant's non-involved left foot/ankle strength to be significantly less than that of the right involved ankle.

The doctor's exam of 7/17/02, before chiropractic care really even ensued, revealed that the claimant was wearing a boot or support on his right foot and was utilizing crutches for ambulation. However, the doctor's exam findings of the claimant's ankle consisted of only 1 sentence in his report. This sentence read: "Right ankle/foot decreased range of motion with pain at lateral ligaments."

The claimant's gait was stated to be normal. The claimant's neurovascular status was reportedly normal. The claimant's upper and lower extremity strength evaluations were reported as normal by the doctor. Yet with all of these minimal and normal findings, the claimant was diagnosed with "lower extremity acroparesthesia, radiculitis, and weakness". This diagnosis was obviously not supported by the exam findings. Please also consider that the chiropractic documentation contained the same vague objective findings on a day to day basis and, on many days, there were no objective findings at all. The chiropractic documentation mostly consisted of subjective complaints and treatment that was rendered. I fail to see how myofascial release, joint manipulation and traction would be needed for an ankle injury, especially that of an avulsion injury. I certainly understand that there was diagnostic evidence of an anterior talofibular ligament avulsion fracture on x-ray and MRI testing; however, as of at least 9/3/02 this seemed to not be clinically significant as the claimant had obviously reached a stationary level of improvement whereby he should have been able to return to work as a teacher. By 9/16/02 the claimant had undergone sufficient passive and active treatment in order to be transitioned back to work as well as to a home based exercise program. The claimant was noted to be a teacher not a roller skater. For this type of injury the Official Disability Guidelines, which is a highly evidence based guideline, only recommends about 8 weeks of physical therapy at decreasing frequencies of 3 times per week and a return to work within 21 days. The return to work at 21 days is in cases of "severe" sprain injury and at the manual/standing work level. This would generally fit the description of a teacher's job. Also, the documentation in the form of repeated strength testing and range of motion testing revealed minimal progression from 7/22/02 through 9/3/02. There was some progression noted; however, the claimant could have appreciated similar results had he simply performed a self rehabilitation program at home to consist of Theraband, active resistive exercises, and rest, ice, compression, and elevation. The improvements via the physician directed care through 9/3/02 did not serve to progress the claimant's condition any faster than that of the natural history of the injury or if he had been instructed in a home based exercise program after a short physician directed program. These types of injuries are fairly common and do not require the extensive treatment that was rendered. If the claimant was having severe problems due to the avulsion fracture, then the claimant would probably need surgical correction of this. However, this did not appear to be the case and I do not see documented evidence to support the need for treatment beyond 9/3/02 and especially beyond 9/16/02 which is the beginning of the services that are in question.