THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-04-3596.M5

MDR Tracking Number: M5-03-1876-01

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. The dispute was received on March 28, 2003.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity chiropractic treatment (myofasical release, therapeutic exercises, and ultrasound therapy). However, the requestor did not prevail office visits. 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** 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. Therapeutic exercises, myofasical release ultrasound therapy and office visits from 04-08-02 through 08-07-02 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

ORDER

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 04-08-02 through 08-07-02 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 5th day of January 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division
RL/gr

NOTICE OF INDEPENDENT REVIEW DECISION

Date: July 2, 2003

RE: MDR Tracking #: M5-03-1876-01
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 was standing on a ladder in order to assist a crane that was placing a large commercial sign into place when he suffered a right knee injury. The claimant also reportedly suffered elbow injury and low back injury; however, it appears the services in question relate to the knee rehabilitation only. At any rate, the claimant's knee was stuck in an awkward position in a ladder and he suffered knee injury which subsequently resulted in 3 surgeries. The first surgery occurred in February 2001 and this encompassed a meniscus repair and another surgery took place on 4/4/01 that consisted of an anterior cruciate ligament repair. The claimant reportedly fell after this date and caused the anterior cruciate ligament tear reconstruction to rupture and the claimant ended up undergoing a third surgery which consisted of an anterior cruciate ligament repair on 1/16/02. The claimant had a lot of difficulty with swelling post operatively and he was even placed on antibiotics because infection was suspected. At any rate, the claimant was recommended by his surgeon, ___, to undergo ultrasound with his chiropractor in order to help control some of the swelling. ___ prescribed ultrasound therapy for this claimant's knee on 4/8/02 and the claimant was documented to have begun some active rehabilitation on 5/10/02. The claimant continued to receive myofascial release and ultrasound throughout the duration of the active care through 8/7/02.

Requested Service(s)

The medical necessity of the outpatient services including chiropractic treatments from 4/8/02 to 8/7/02.

Decision

I agree with the insurance carrier that the office visits as billed from 4/8/02 through 5/9/02 were not considered to be reasonable or medically necessary as billed. I agree with the insurance carrier that office visits as billed from 5/10/02 through 8/7/02 were not reasonable or medically necessary. I disagree with

the insurance carrier and find that all other services rendered from 4/8/02 through 8/7/02 were reasonable and medically necessary.

Rationale/Basis for Decision

The documentation, mainly in the form of chiropractic documentation, reveals that the office visits as billed with a manipulation code from 4/8/02 through 5/9/02 were billed on a daily basis and the chiropractic documentation does not support a rationale for why this was done. Chiropractic manipulation of a knee without explanation of the type of manipulation that was done would not be considered reasonable or medically necessary in this particular setting. The knee only has 2 ranges of motion, those being flexion and extension, and I fail to see how an osseous adjustment of the knee would be necessary in this particular situation. The office visit notes as documented from 4/8/02 through 5/9/02 also show this to be a very straight forward minimal type of situation in which the 99213 code was not, in my opinion, justified. I do believe that the office visits as documented were of the 99212 variety and should have been billed at once per week from 4/8/02 through 5/9/02. The reason for this was that the claimant was mainly receiving ultrasound and myofascial release, and there was no need to see a doctor on a daily basis while this was being undertaken. The treating surgeon had recommended ultrasound and there was no need during this time period for the claimant to see the doctor on a daily basis while this was being performed. Some office visits would be considered reasonable and medically necessary from 5/10/02 through 8/7/02; however, there would be no need for daily or 3 times per week office visits during the routine post operative rehabilitation program. I do feel that office visits once per week at the 99213 level would be considered reasonable and medically necessary from 5/10/02 through 8/7/02. It is not reasonable or medically necessary to see a physician on every single visit of post operative physical therapy. As far as the rest of the services which included myofascial release, active therapy and ultrasound, I do feel that all of these services as rendered from 4/8/02 through 8/7/02 were considered reasonable and medically necessary for several reasons. The highly evidence based Official Disability Guidelines 2003 edition recommends 34 physical therapy visits over a 16 week period for treatment of an anterior cruciate ligament repair. This claimant underwent 2 surgeries for an anterior cruciate ligament tear and had undergone 34 visits of active treatment from 5/10/02 through 8/5/02. This would be well within the recommendations of the Official Disability Guidelines once active care was begun. It is also my opinion that it was well documented that the claimant definitely needed the ultrasound and myofascial release in order to control the swelling that was associated with the injury as well as occurred during the active rehabilitation. It was well documented that the claimant was weaned from ultrasound on one or two occasions and this resulted in increased knee swelling. Therefore, even though the ultrasound and myofascial release would be considered passive care modalities, I do feel they were justified by the documentation in this particular instance. The services, while being somewhat voluminous, were considered to be reasonable and medically necessary given this particular situation in which the claimant essentially underwent 3 surgeries. An anterior cruciate ligament tear is more serious from a post rehabilitation point of view and the highly evidence based Official Disability Guidelines recommend 34 visits of physical therapy over a 16 week period for this particular problem and it should also be remembered that this claimant had 2 anterior cruciate ligament operations. It should also be remembered that the claimant is required to go up and down ladders during his normal duties as an electrician and for this reason I do feel that the amount of treatment would be considered reasonable and medically necessary in order to restore some optimum performance to the claimant. The claimant was definitely not documented to be an office worker or to be employed in a sedentary type position, therefore the rehabilitation would be considered reasonable and medically necessary.