

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent.

The requestor submitted a medical dispute resolution request on 3/26/03 and was received in the Medical Dispute Resolution on 4/1/03. The disputed date of service 3/28/02 is not within the one year jurisdiction in accordance with Rule 133.308(e)(1) and will be excluded from this Finding and Decision.

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(q)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$650.00** 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 IRO 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 chiropractic treatment, including office visits and therapies from 7/25/02 through 11/22/02 were found to be medically necessary. The treatment/services provided from 4/2/02 through 7/8/02 was not medically necessary. The respondent raised no other reasons for denying reimbursement for these chiropractic treatment including office visits and therapies from 7/25/02 through 11/22/02 charges.

This Finding and Decision is hereby issued this 12<sup>th</sup> day of August 2003.

Carol R. Lawrence  
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 from 4/2/02 to 11/22/02 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 12<sup>th</sup> day of August 2003.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

RL/crl

**IRO Certificate #4599**

**NOTICE OF INDEPENDENT REVIEW DECISION**

July 29, 2003

**Re: IRO Case # M5-03-1902-01**

Texas Worker's Compensation Commission:

\_\_\_ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to \_\_\_ for an independent review. \_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, \_\_\_ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Orthopedic Surgery. He or she has signed a certification statement attesting 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 referral to \_\_\_ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the \_\_\_ reviewer who reviewed this case, based on the medical records provided, is as follows:

### History

The patient is a 47-year-old female who suffered an injury to her right knee on \_\_\_\_\_. The patient was evaluated. She underwent nonoperative treatment initially. She subsequently underwent arthroscopy of her right knee on 1/3/01, and again on 4/23/01. She was found to have torn medial meniscal cartilage and chondromalacia of the knee. The patient continued to have chronic right knee pain. She again underwent right knee arthroscopy on 11/14/01. At that time she was found to have severe chondromalacia of the right knee. Despite undergoing rehabilitation following arthroscopy, the patient continued to experience significant pain and limited range of motion in the right knee. Prior to knee replacement surgery, the patient was found to have flexion contractures of the right knee with a range of motion noted to be 5 degrees to 85 degrees. The patient underwent a right total knee arthroplasty on 7/8/02. Following surgery, the patient attended rehabilitation with her treating chiropractor. The patient's right knee motion improved to 0 to 90 degrees. A manipulation of the right knee under anesthesia was attempted in 12/02 with no significant improvement.

### Requested Service(s)

Chiropractic treatments 4/1/02-11/22/02.

### Decision

I agree with the carrier's decision to deny the requested treatment rendered from 3/28/02 through 7/8/02. I disagree with the decision to deny therapeutic treatments following the knee replacement surgery up until 11/22/02.

### Rationale

The rationale to perform a knee replacement to was alleviate pain from end stage arthritis. The best predictor of postoperative range of motion following knee replacement surgery is the preoperative range of motion. The patient suffered from significant flexion contractures prior to surgery. Preoperatively, she was diagnosed with arthrofibrosis. It is not realistic to expect a significant improvement in her range of motion postoperatively. Given the findings at arthroscopy in 11/01, some limited therapy following arthroscopy was reasonable. However, continued therapy with no reasonable expectation of improved range of motion due to end stage degenerative arthritis is not medically necessary. Therefore, it is my opinion that continuing therapeutic treatments from 3/28/02 until the knee replacement surgery was not medically necessary.

Following knee replacement surgery, supervised therapeutic exercises 3 days per week for up to 3 or 4 months is often medically indicated, especially in a case with preexisting arthrofibrosis. In my opinion, no further supervised therapy would be recommended after 11/22/02. It would not be reasonable to expect any further

improvements in range of motion of the patient's right knee. The patient might benefit from a home strengthening exercise program performed on her own.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

Sincerely,