THIS DECISION HAS BEEN APPEALED. THE FOLLOWING
IS THE RELATED SOAH DECISION NUMBER: 453-03-4135.M5

MDR Tracking Number: M5-03-2080-01

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, 2003 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 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 physical medicine treatment, therapeutic exercises, neuromuscular re-education, electrical stimulation, ultrasound, myofascial release, office visits with manipulations 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 the physical medicine treatment, therapeutic exercises, neuromuscular re-education, electrical stimulation, ultrasound, myofascial release, office visits with manipulations 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 5/20/02 through 12/9/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 27th day of June 2003.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

NOTICE OF INDEPENDENT REVIEW DECISION

Date: June 23, 2003

RE: MDR Tracking #: M5-03-2080-01
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 an Orthopedic Surgeon physician reviewer who is board certified in Orthopedic Surgery. The Orthopedic Surgeon 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 case involves a 40 year old right handed male who sustained a closed fracture of the right radius, closed dislocation of the right elbow, as well as limited disruption of the distal radial ulnar joint in a work related injury on ___. The right arm became entangled in the twisting shaft of a mechanized farm device, namely the power takeoff. Seen in an emergency setting, he underwent surgery that same day which involved plating of the radial shaft fracture after closed reduction of the elbow fracture, as well as ligamentous repair to the distal radial ulnar joint. While there is a gap in the supplied records, the injured worker apparently was released to light duty as of 3/5/02, with formal physical therapy/occupational therapy apparently beginning for the first time on 7/3/02. The therapy continued typically twice weekly until he was discharged on 9/20/02, with subjective and objective improvement.

Requested Service(s)

Physical therapy treatment and services from 7/18/02 to 9/20/02.

Decision

I disagree with the insurance carrier and find that the above services were medically necessary.

Rationale/Basis for Decision

In thorough review of the supplied records and with close correlation of the documentation with the dates of service, and in light of the clinical diagnosis and treatment, it is my opinion that the physical therapy treatments were reasonable, appropriate, and medically necessary. The level of supervision/services as well as the volume of services seems quite consistent with the injury, consistent with good medical care, and consistent with what appears to be good documentation by the physical therapy clinic in a contemporary fashion. The treatment provided by the therapist is consistent with the outlined plan as of 7/3/02, namely the use of a licensed therapist in a one to one setting. The treatment approach appears consistent with the request of the treating physician as does the duration and volume. Compared with many cases which I have reviewed, this instance does not suggest an abusive use of services. Unless clearly abusive or fraudulent, the therapist and treating physician should have been allowed some discretion in services provided consistent with their clinical assessment of the patient. The individuals providing the services were in a better position to determine the necessity and appropriateness of services provided in good faith, as contrasted to retrospective review which denied payment for services provided.