

MDR Tracking Number: M5-03-2139-01

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 adverse determination that the therapeutic exercises, aquatic therapy and electrical stimulation 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 therapeutic exercises, aquatic therapy and electrical stimulation 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 5/7/02 through 5/22/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 1<sup>st</sup> day of July 2003.

Margaret Q. Ojeda  
Medical Dispute Resolution Officer  
Medical Review Division

MQO/mqo

**IRO Certificate #4599**

June 27, 2003

**Re: IRO Case # M5-03-2139-01**

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, Rule 133.308 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 injured his left lower extremity on \_\_\_ when a coworker backed up an airline baggage cart onto the patient's left leg. Initial x-rays were within normal limits, and the patient was initially treated non-operatively. The patient, however continued to experience pain in his left knee, and an MRI demonstrated evidence of a low grade tear in the posterior horn of the lateral meniscus, grade 1 chondromalacia of the patella, a suprapatellar plica, and minimal sprain of the ACL. On 2/18/02 the patient underwent left knee arthroscopy with complete synovectomy, partial medial meniscectomy, and chondroplasty of loose patellar articular cartilage. The patient underwent postoperative physical therapy beginning on 3/5/02. He was treated with therapeutic exercises and aquatic therapy. He attended therapy three times per week from 3/5/02 to 5/28/02 primarily for rehabilitation of the left knee following surgery.

#### Requested Service(s)

Therapeutic exercises, aquatic therapy, electrical stimulation 5/7/02 – 5/22/02

#### Decision

I agree with the carrier's decision to deny the requested treatment

#### Rationale

At the time of surgery the patient was found to have some arthritis in his knee, reactive synovitis, and a tear of the posterior horn of the medial meniscus. Following surgery, the patient underwent land based physical therapy and aquatic therapy.

He had attended 24 visits of prescribed therapy from 3/5/02 to 5/2/02. He had made good progress objectively with his range of motion and strength during this time. He continued to suffer from subjective pain in his knee as well as multiple other areas. In my opinion, based on the records provided for this review, the patient had undergone an adequate amount of physical therapy (both prior to surgery and after surgery from 3/5/02 – 5/2/02) for his conditions (left knee and groin injuries). On 5/2/02 the patient had made enough progress with physical therapy of the left knee to be released to a home exercise program.

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

Sincerely,

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