MDR Tracking Number: M5-03-2299-01

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 11-26-02.

The IRO reviewed the office visits, therapeutic exercises, joint mobilization, myofascial release, and manual traction.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor** (insurance carrier) **prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the Respondent (health care provider) and non-prevailing party to refund the **Requestor** (insurance carrier) **$460.00** 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.

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. The office visits, therapeutic exercises, myofascial release, joint mobilization, and manual traction were found to be not medically necessary.

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 (health care provider) to refund the paid medical fees in accordance with Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the Requestor (insurance carrier) within 20 days of receipt of this order. This Order is applicable to dates of service 4-10-02 to 4-24-02 in this dispute.

This Order is hereby issued this 12th day of October 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

DZT/dzt

NOTICE OF INDEPENDENT REVIEW DECISION

Date: June 7, 2004

MDR Tracking #: M5-03-2299-01
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 who has an ADL certification. The 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.

Documents reviewed from the provider:

A response letter, a letter from PRI, several statement letters and daily notes from the days in question.

Documents reviewed from the carrier:

EOBs and dates in dispute.

Clinical History

According to the supplied documentation, it appears that the claimant sustained an injury on ___ when she fell off of a forklift sustaining injuries to her left knee, left wrist, mid and low back. The claimant reported to ___ on 02/07/2002 for evaluation and treatment. ___ diagnosed the claimant with a thoracic, lumbar, left knee and wrist sprain. The claimant began chiropractic therapy, which included passive and active modalities. The claimant underwent a MRI on 02/11/2002 that apparently revealed a tear to the lateral meniscus. A MRI of the thoracic region revealed an older compression fracture, which was unrelated. The claimant was seen by ___ on or about 04/01/2002. ___ felt the claimant needed surgery. Chiropractic therapy continued. The documentation ends here.

Requested Service(s)

Please review and address the medical necessity of the outpatient services rendered between 04/10/2002 and 04/24/2002 that included 99213, 97110, 97250, 97265 and 97122.

Decision

I agree with the insurance carrier that the services rendered were not medically necessary.

Rationale/Basis for Decision

According to the supplied documentation, it appears that the claimant sustained a sprain/strain to her left wrist, thoracic and lumbar regions. The claimant also sustained a tear to her left lateral meniscus. The conservative approach is seen as reasonable and medically necessary until the decision was made that surgery was necessary. No documentation was supplied that the therapy rendered was needed beyond the date ___ decided surgery was necessary, therefore the therapy beyond the date on or about 04/01/2002 is not considered medically necessary. Ongoing care is not seen as necessary and is not supported by current literature. A search of current medical guidelines including **Official Disability Guidelines, Occupational Medicine Practice Guidelines and Essentials of Musculoskeletal Care** produced no findings that would support therapy once a decision had been made that surgery was needed to facilitate the healing process. The supplied documentation did not support any additional treatment to the left wrist, thoracic or lumbar regions any longer than the initial 6-8 weeks. The medical necessity of treatment after 04/04/2002 would be limited to rehabilitate the left knee *after* surgery.