MDR Tracking Number: M5-03-2924-01

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 7-14-03.

The Medical Review Division has reviewed the IRO decision and determined that the total amount recommended for reimbursement does not represent a majority of the medical fees of the disputed healthcare and therefore; the **requestor did not prevail** in the IRO decision. Consequently, the requestor is not owed a refund of the paid IRO fee.

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. The ultrasound, therapeutic procedures, myofascial release, office visits, electrical stimulation, and physical therapy from 1-27-03 through 3-21-03 were found to be medically necessary. The ultrasound, therapeutic procedures, myofascial release, office visits, electrical stimulation, and physical therapy from 3-24-03 through 5-27-03 were not found to be medically necessary. The respondent raised no other issues for denying reimbursement for the above listed services.

The above Findings and Decision are hereby issued this 13th day of November 2003.

Dee Z. Torres
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 1-27-03 through 3-21-03 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 13th day of November 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

October 16, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-2924-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History
This case concerns a male who sustained a work related injury on ___. The patient reported that while at work he injured his knee by kneeling on the metal floor beam. The diagnoses for this patient included chronic pain syndrome, s/p arthroscopy and bilateral meniscectomy. The patient underwent surgery on 5/15/02 and 11/13/02. Post surgical rehabilitation was begun that consisted of ultrasound, therapeutic procedures, myofascial release, physical therapy and electrical stimulation. The patient was also treated with knee injections for continued complaints of pain.

Requested Services
Ultrasound, therapeutic procedures, myofascial release, office visits, electrical stimulation, physical therapy from 1/27/03 through 5/27/03.

Decision
The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is partially overturned.

Rationale/Basis for Decision
The ___ chiropractor reviewer noted that this case concerns a male who sustained a work related injury to his knee on ___. The ___ chiropractor reviewer also noted that the patient underwent knee surgery on 5/15/02 and 11/13/02. The ___ chiropractor reviewer indicated that this patient was treated postoperatively with rehabilitation. However, the ___ chiropractor reviewer explained that the patient showed no improvement with the treatment rendered except after a cortisone shot. The ___ chiropractor reviewer also explained that 8 weeks of therapy is

acceptable and more treatment would be warranted if the patient were making steady improvement. The ___ chiropractor reviewer further explained that this patient showed no improvement during the entire treatment. Therefore, the ___ chiropractor consultant concluded that the ultrasound, therapeutic procedures, myofascial release, office visits, electrical stimulation, physical therapy from 1/27/03 through 3/21/03 were medically necessary to treat this patient's condition. However, the ___ chiropractor consultant also concluded that the ultrasound, therapeutic procedures, myofascial release, office visits, electrical stimulation, physical therapy from 3/24/03 through 5/27/03 were not medically necessary to treat this patient's condition.

Sincerely,