MDR Tracking Number: M5-03-3282-01

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, 133.307 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. This dispute was received on August 14, 2003.

The IRO reviewed myofascial release, therapeutic exercises, interactive individual medical psychotherapy rendered on 8/15/02 through 11/25/02 denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On October 15, 2003, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	**CPT CODE**	**Billed**	**Paid**	**EOB Denial Code**	**MAR$**	**Reference**	**Rationale**
11/25/02	90855	$180.00	$0.00	A	$180.00	Rule 133.306 (h) CPT code descriptor	The carrier is denying the interactive individual medical psychotherapy. Per Rule 133.306 (h)(4) preauthorization is required for psychotherapy. The requestor failed to submit relevant information to support that preauthorization was obtained for the charge in dispute. Reimbursement is therefore not recommended.
TOTAL		$180.00	$0.00	A	$180.00		The requestor is not entitled to reimbursement.

This Decision is hereby issued this 5th day of February 2004.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division
MQO/mqo

NOTICE OF INDEPENDENT REVIEW DECISION

Date: October 6, 2003

RE: MDR Tracking #: M5-03-3282-01
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 that has ADL certification. The Chiropractic 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
According to the supplied documentation, it appears that ___ sustained an injury while at work at ____ on ___. He apparently injured his left knee when he slipped and fell on a ramp. The claimant originally was seen at ___where he had x-rays performed and was given some medications. On 07/09/2001, the claimant was seen by ___ for an evaluation. A MRI was performed on 07/12/2001 and revealed a thin linear signal extending to the inferior surface of the posterior horn of the lateral meniscus consistent with a tear. The claimant underwent chiropractic therapy. It appears that conservative therapy failed and the claimant underwent surgery to his left knee on 04/04/2002. The claimant underwent post-surgical rehabilitation under ___. The claimant received rehabilitation from 05/15/2002 until 09/26/2002. The claimant then received 2 weeks of work conditioning.

Requested Service(s)
Please review and address the medical necessity of the outpatient services including myofascial release, therapeutic exercises, and interactive medical psychotherapy.

Decision
I agree with the insurance company that the services requested were not medically necessary.

Rationale/Basis for Decision
The documentation supplied validates therapy for the claimant's post-surgical status. The claimant should have received 8 weeks of post-surgical rehabilitation. The claimant received therapy from 05/15/2002 until 09/19/2002, which is approximately 18 weeks of therapy. The documentation supplied does not support the length of this treatment. The claimant had undergone an extensive amount of therapy prior to his surgery and would not support the extended amount of therapy after his surgery. At the end of an 8-week trial, it would either be necessary for the claimant to begin a home exercise program or a work hardening/conditioning program. Since the claimant had extensive amounts of therapy, his treatment could have continued at home with monthly visits with his treating doctor. Ongoing therapy beyond an 8-

week protocol was neither found reasonable or medically necessary for the compensable injury sustained on ___. There was not enough of documented objective information supplied to warrant the claimant being referred to a counselor for further evaluation. If counseling would be necessary, it would be included in a work hardening program.