

MDR Tracking Number: M5-03-3324-01

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 (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 September 10, 2003.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity for therapeutic exercises and neuromuscular re-education. Therefore, upon receipt of this Order and in accordance with § 133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$650.00** 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.

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 respondent raised no other reasons for denying reimbursement of therapeutic exercises and neuromuscular re-education.

This Findings and Decision is hereby issued this 1st day of December 2003.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

GR/gr

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 09-17-02 through 10-31-02 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 1st day of December 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division
RL/gr

NOTICE OF INDEPENDENT REVIEW DECISION

November 24, 2003

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: MDR Tracking #: M5-03-3324-01
IRO Certificate #: IRO4326

___ 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 §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the rendered 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 ___ physician reviewer who is board certified in Orthopedic Surgery which is the same specialty as the treating physician. The ___ 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 patient sustained an injury to her left ankle and foot on ___, mechanism unknown. She had a previous surgery on the left ankle but continued to have pain. She saw an orthopedic surgeon who diagnosed her with probable posterior tibial tendonitis. The patient underwent left posterior tibial tendon tenolysis and reconstruction on 07/11/02. She subsequently began a course of physical therapy on 09/03/02.

Requested Service(s)

Therapeutic exercise and neuromuscular re-education from 09/17/02 through 10/31/02

Decision

It is determined that the therapeutic exercise and neuromuscular re-education from 09/17/02 through 10/31/02 were medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The documentation from the surgeon notes that the patient's cast was removed on 08/23/02 and she was placed in a Cam walker. She began physical therapy and by 09/05/02, she was able to start discontinuing the crutches, remaining in the Cam walker and going to physical therapy. This treatment plan is totally appropriate as prescribed for this type of surgery. It takes a long time for a patient to recover from posterior tibial tendon surgery. This is a complex surgical procedure and requires a good rehabilitation program. The physical therapy notes indicate that the patient underwent appropriate physical therapy and the surgeon's notes indicate a need for that therapy. Therefore, it is determined that the therapeutic exercise and neuromuscular re-education from 09/17/02 through 10/31/02 were medically necessary.

Sincerely,