THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-04-2029.M5

MDR Tracking Number: M5-03-3385-01

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 August 26, 2003.

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 determination that the therapeutic exercises, myofascial release, joint mobilization, neuromuscular re-education, range of motion and physical therapies 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 fees were the only fees involved in the medical dispute to be resolved. As the therapeutic exercises, myofascial release, joint mobilization, neuromuscular re-education, range of motion and physical therapy were not found to be medically necessary, reimbursement for dates of service from 4/15/03 through 6/13/03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 14th day of November 2003.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

NOTICE OF INDEPENDENT REVIEW DECISION

Date: November 7, 2003

RE: MDR Tracking #: M5-03-3385-01
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 an Orthopedic Surgeon physician reviewer who is board certified in Orthopedic Surgery and has an ADL Level 2. The Orthopedic Surgeon 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

The claimant underwent revision anterior cruciate ligament reconstruction of the right knee on 1/9/03, allegedly related to a compensable work injury of ___.

Requested Service(s)

Therapeutic procedures, myofascial release, joint mobilization, "neuro re-education", range of motion and physical therapy for dates inclusive of 4/15/03 through 6/13/03.

Decision

I agree with the insurance carrier that the requested services are not medically necessary.

Rationale/Basis for Decision

According to clinical note dated 1/20/03 by the treating surgeon, the claimant had an uncomplicated post operative course and was doing well with a stable reconstruction. According to a physical therapy note dated 2/26/03 the claimant had completed 12 treatments with good compliance and was utilizing a straight cane for community ambulation. According to a physical therapy note dated 4/8/03 the claimant was ambulating 500+ feet and exhibited functional range of motion (extension 0°, flexion 122°) and normal quadriceps and hamstring strength. Generally continued supervised physical therapy is indicated when there is documentation of significant range of motion or strength deficits. In this clinical setting, there is no clearly documented clinical rationale to indicate the medical necessity of continued supervised physical therapy when the claimant exhibited functional range of motion and normal quadriceps and hamstring strength 3 months status post successful anterior cruciate ligament reconstruction.