

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 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 Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(q)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$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.

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 Chiropractic treatment / services (including therapeutic procedures / therapies, mobilization and supplies) was found to be medically necessary. The respondent raised no other reasons for denying reimbursement for these Chiropractic treatment/services (including therapeutic procedures / therapies, mobilization and supplies) charges.

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 1/22/01 through 4/25/01 in this dispute and IRO fee.

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 15th day of November 2002.

Carol R. Lawrence  
Medical Dispute Resolution Officer  
Medical Review Division

CRL/crl

**IRO Certificate #4599**

## NOTICE OF INDEPENDENT REVIEW DECISION

November 1, 2002

**Re: IRO Case # M5-02-2488**

Texas Worker's Compensation Commission:

\_\_\_ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to \_\_\_ for an independent review. \_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, \_\_\_ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Physical Medicine and Rehabilitation. He or she has signed a certification statement attesting 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 referral to \_\_\_ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the \_\_\_ reviewer who reviewed this case, based on the medical records provided, is as follows:

### History

The patient slipped and fell in \_\_\_. He was diagnosed with lumbrosacral sprain, left knee sprain, inner thigh muscle sprain. He was treated with medications and physical therapy. An MRI of the left knee 2/14/01 showed a grade three tear in the posterior horn of the medial meniscus. On 3/21/01 the patient underwent a left knee arthroscopy including lateral meniscectomy and synovectomy. The patient had pre and post operative physical therapy. The post operative physical therapy was interrupted. His post operative physical therapy was interrupted by hernia repair. It appears that the patient's knee symptoms were improving while in physical therapy. Following the hernia repair the patient was treated in a work conditioning program. An FCE 7/9/01 showed the patient to be performing at a heavy physical demand level. During the course of the patient's treatment beginning 1/18/01 prior to surgery the patient had 16 physical therapy treatments. Post operatively he had 10 physical therapy treatments for the knee.

Requested Service

Physical therapy 1/22-1/24/01, 4/9-4/25/01

Decision

I disagree with the carrier's decision to deny the requested treatment.

Rationale

The physical therapy treatments 1/22-1/24/01 represented the second through fourth treatments following the patient's injury. They were necessary to treat the acute phase of the injury. Conservative treatment for injuries such as the patient's includes physical therapy to reduce pain and inflammation and try to get the patient back to work as soon as possible. The physical therapy treatments 4/9-4/25/01 included five treatments for the patient's knee. The patient had had arthroscopic surgery on 3/21/01 and a post operative course of physical therapy was necessary for range of motion, strengthening as well as control of inflammation. It was reasonable and necessary.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

**YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

**If disputing a spinal surgery prospective decision**, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

**If disputing other prospective medical necessity (preauthorization) decisions**, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:  
Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P O Box 40669,  
Austin, TX 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308(t)(2)).

Sincerely,