

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

SOAH DOCKET NO. 453-04-4568.M5

MDR Tracking Number: M5-04-0147-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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 9-10-03.

The IRO reviewed office visits, electric stimulation, therapeutic procedure, mechanical traction, supplies, and myofascial release from 9-27-02 through 12-20-02.

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.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 11-24-03, 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 requestor failed to submit relevant information to support components of the fee dispute in accordance with Rule 133.307(g)(3)(A-F). No reimbursement recommended.

The above Findings and Decision is hereby issued this 26th day of February 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

February 24, 2004

**NOTICE OF INDEPENDENT REVIEW DECISION
Amended Determination**

MDR Tracking #: M5-04-0147-01

___ 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 48 year-old female who sustained a work related injury on ___. The patient reported that while at work she was carrying a box when she tripped and fell injuring her right knee. The patient underwent arthroscopic photos in 7/02, X-Rays of the right knee on 6/18/03 and an MRI on 3/25/02. The diagnosis for this patient is internal derangement of the right knee. Initial treatment for this patient included 45 weeks of physical therapy and anti-inflammatory medications. On 7/24/02 the patient underwent arthroscopic debridement of chondral defect and drilling/lateral patellar release of the right knee. The patient has also been treated with pain management, injections, work hardening and chiropractic care.

Requested Services

Office visits, electric stimulation, therapeutic procedure, mechanical traction, supplies/materials and myofascial release from 9/27/02 through 12/20/02.

Decision

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

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a 48 year-old female who sustained a work related injury to her right knee on ___. The ___ chiropractor reviewer also noted that the diagnosis for this patient included internal derangement of the right knee. The ___ chiropractor reviewer further noted that the patient underwent arthroscopic knee surgery followed by postoperative therapy. The ___ chiropractor reviewer explained that the documentation provided does not demonstrate that the patient showed any objective evidence of improvement with treatment rendered. The ___ chiropractor reviewer also explained that after

6-8 weeks of treatment without the patient showing improvement, the treatment should be discontinued. The ___ chiropractor reviewer further explained that the patient's impairment rating of 11/26/02 was worse compared to the impairment rating of 5/31/02. Therefore, the ___ chiropractor consultant concluded that the office visits, electric stimulation, therapeutic procedure, mechanical traction, supplies/materials and myofascial release from 9/27/02 through 12/20/02 were not medically necessary to treat this patient's condition.

Sincerely,