

MDR Tracking Number: M5-04-0340-01

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 10-2-03.

The IRO reviewed aquatic therapy, electrical stimulation, joint mobilization, office visits, therapeutic exercises, vasopneumatic devices, hot/cold packs, myofascial release, ROM, unlisted cardiovascular procedure, and total evaluation of body including hands on 10-1-02 through 3-26-03.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the majority of the medical necessity issues. The IRO concluded that the therapeutic exercises on 10-1-02 through 1-29-03 and ROM from 10-1-02 through 3-26-03 **were** medically necessary. The IRO agreed that the aquatic therapy on 10-1-02, 10-4-02, 10-7-02, and 10-9-02, electrical stimulation, vasopneumatic device, myofascial release, hot/cold packs, joint mobilization, unlisted cardiovascular procedure, total body evaluation including hands, and office visit from 10-1-02 through 3-26-03 **were not** medically necessary. 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 \$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.

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

On 12-17-03, 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 following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Max. Allowable Reimbursement)	Reference	Rationale
11/11/02	97032	\$20.00	\$0.00	F	\$22.00	Rule 133.307(g)(3) (A-F)	Carrier's denial states "F- minimum of 4 hrs required after 1 st week of WH/WC." This is not a WH/WC code. The requestor failed to submit relevant information to support

							delivery of service. No reimbursement recommended.
TOTAL		\$20.00	\$0.00				The requestor is not entitled to reimbursement.

The above Findings and Decision are hereby issued this 1st day of April 2004.

Dee Z. Torres
 Medical Dispute Resolution Officer
 Medical Review Division

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for 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 for dates of service 10-1-02 through 3-26-03 in this dispute.

This Order is hereby issued this 1st day of April 2004.

Roy Lewis, Supervisor
 Medical Dispute Resolution
 Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

**Amended Letter
 Note: Decision**

December 10, 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 #: M5-04-0340-01
 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 Rule §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 matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___'s health care professional 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 injuries to bilateral wrists and knees on ___ when she slipped and fell, trying to break her fall with her hands/wrists and landing on her knees. She underwent arthroscopic surgery on her right knee on 08/06/02 and saw a chiropractor for post operative rehabilitation.

Requested Service(s)

The aquatic therapy, electrical stimulation, joint mobilization, office visit, therapeutic exercises, vasopneumatic devices, hot or cold pack therapy, myofascial release, range of motion measurements, unlisted cardiovascular procedure, and total evaluation of body including hands from 10/01/02 through 03/26/03

Decision

It is determined that the therapeutic exercises from 10/01/02 through 01/29/03, and range of motion measurements from 10/01/02 through 03/26/03 were medically necessary to treat this patient's condition. However, the use of aquatic therapy on 10/01/02, 10/04/02, 10/07/02 and 10/09/02, electrical stimulation, vasopneumatic devices, myofascial release, hot/cold packs, joint mobilization, unlisted cardiovascular procedure, and total body evaluation including hands from 10/01/02 through 03/26/03 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The patient began a course of post operative physical therapy on 08/20/02 and her initial flexion was 90 degrees and extension was -25 degrees. Treatments consisted of therapeutic exercises, occasional use of joint mobilization, aquatic therapy on 10/01/02, 10/04/02, 10/07/02, and 10/09/02, hot/cold packs, electrical stimulation, and myofascial release. Progress reports were provided for dates of service 08/20/02, 09/17/02, 10/15/02, and 12/13/02. No further progress reports were provided for review but the doctor's letter indicated that the patient was subsequently re-examined on 01/29/03 and no appreciable change was noted in her condition.

The therapeutic exercises from 10/01/02 through 01/29/03 were medically necessary. Haldeman et al indicate that it is beneficial to proceed to the rehabilitation phase of care as rapidly as possible to minimize dependence on passive forms of treatment/care and reaching the rehabilitation phase as rapidly as possible and minimizing dependence on passive treatment usually leads to the optimum result. (*Haldeman, S., Chapman-Smith, D., and Petersen, D., Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen, Gaithersburg, Maryland, 1993*).

The use of aquatic therapy on 10/01/02, 10/04/02, 10/07/02, and 10/09/02 was not established by the records reviewed. The patient was two months post surgery and was involved in land-based therapy. The continued use of aquatic therapy eight weeks post surgery was not medically necessary.

According to the Philadelphia Panel Evidenced-Based Clinical Practice Guidelines on Selected Rehabilitation Interventions for Knee Pain, transcutaneous electrical nerve stimulation (TENS) and therapeutic exercises were beneficial for knee osteoarthritis, and there was good agreement with these recommendations from practitioners (73% for TENS, 98% for exercises). For several interventions and indications (e.g., thermotherapy, therapeutic ultrasound, massage, and electrical stimulation), there was a lack of evidence regarding efficacy. (*Philadelphia Panel Evidenced-Based Guidelines on Selected Rehabilitation Interventions for knee Pain. Phys Ther. 2001;81:1675-1700*).

Office visit on 03/26/03 was not medically necessary base on documentation reviewed. Therefore, it is determined that the therapeutic exercises from 10/01/02 through 01/29/03, and range of motion measurements from 10/01/02, through 03/26/03 were medically necessary. However, the use of aquatic therapy on 10/01/02, 10/04/02, and 10/09/02, electrical stimulation, vasopneumatic devices, myofascial release, hot/cold packs, joint mobilization, unlisted cardiovascular procedure, office visit on 03/26/04 and total body evaluation including hands from 10/01/02 through 03/26/03 were not medically necessary.

Sincerely,