

MDR Tracking Number: M5-04-0429-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 10-01-03

The IRO reviewed therapeutic exercises, gait training, measure blood oxygen level (94760), neuromuscular reeducation, and office visits rendered from 12-31-02 through 02-24-03 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity for therapeutic exercises, gait training, measure blood oxygen level (94760), neuromuscular reeducation, and office visits. Consequently, the requestor is not owed a refund of the paid IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved.

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

On 12-19-03, 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 (Maximum Allowable Reimbursement)	Reference	Rationale
01/02/03	29125	\$61.00	0.00	F	\$61.00	MFG SGR (B)(2)(e)	Therapy and progress notes do not support the delivery of service. Reimbursement is not recommended
TOTAL		\$61.00					The requestor is not entitled to reimbursement.

This Decision is hereby issued this 5th day of March 2004.

Georgina Rodriguez
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 Decision is applicable for dates of service 12-31-02 through 02-24-03 in this dispute.

This Order is hereby issued this 5th day of March 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

December 22, 2003

NOTICE OF INDEPENDENT REVIEW DECISION Corrected Letter

RE: MDR Tracking #: M5-04-0429-01

___ 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 physician 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. This physician is board certified in physical medicine and rehabilitation. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician 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 ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 43 year-old male who sustained a work related injury on ___. The patient reported that while at work he injured his right knee. An MRI of the right knee dated 9/10/02 showed an unstable horizontal cleavage tear through the posterior horn of the medial meniscus, mild joint effusion and subchondral microtrabecular edema consistent with microtrabecular fracture of the lateral tibial plateau. The patient was referred for an orthopedic evaluation and the patient subsequently underwent right knee surgery in November 2002. Four weeks after surgery the patient was referred for postoperative rehabilitation that included therapeutic exercises, gait training, electrical stimulation and cold packs.

Requested Services

Therapeutic exercises, gait training, measure blood oxygen level, neuromuscular reeducation, office out/patient est. from 12/31/02 through 2/24/03.

Decision

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

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 43 year-old male who sustained a work related injury on ___. The ___ physician reviewer indicated that the patient was treated with physical therapy for range of motion in the right knee 4 weeks following arthroscopic surgery for a meniscal tear. The ___ physician reviewer explained that the physical therapy consisted of modalities that were designed to facilitate return to work. The ___ physician reviewer noted that the patient made good progress in range of motion and strength in right knee from 12/31/02 through 2/24/03. The ___ physician reviewer explained that by 2/24/03 the patient had near normal range of motion in right knee and minimal weakness in right quad. The ___ physician reviewer also explained that the postoperative rehabilitation was essential to regain full function of the injured knee and was consistent with standard medical practice. Therefore, the ___ physician consultant concluded that the therapeutic exercises, gait training, measure blood oxygen level, neuromuscular reeducation, office out/patient est. from 12/31/02 through 2/24/03 were medically necessary to treat this patient's condition.

Sincerely,