

MDR Tracking Number: M5-04-0484-01

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 10-15-03. The disputed dates of service 5-10-02 through 10-14-02 are untimely and ineligible for review per TWCC Rule 133.307 (d)(1) which states that a request for medical dispute resolution shall be considered timely if it is received by the Commission no later than one year after the dates of service in dispute. The Commission received the medical dispute on 10-15-03.

The IRO reviewed office visits, therapeutic procedures, joint mobilization, hot/cold packs, neuromuscular re-education, myofascial release, ROM testing, muscle testing, required reports, unusual travel and physician telephone conference from 11-13-02 through 4-2-03.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. The IRO agreed with the previous adverse determination that the unusual travel, required reports, office visits (99211 and 99213), joint mobilization, myofascial release, hot/cold packs, and neuromuscular re-education **were not** medically necessary. The IRO concluded that the therapeutic exercises, office visits (99212), telephone conference, ROM, and muscle testing **were** medically necessary. 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 12-18-03, 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 review can be conducted; therefore, no reimbursement recommended.

This Decision is hereby issued this 5th day of May 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 10-15-02 through 4-2-03 in this dispute.

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

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

REVISION 3 – 5/6/04

December 16, 2003
IRO Certificate # 5259

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ____, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY

Available information suggests that this patient reports injury to her left knee while stepping off an elevator, experiencing a twisting type fall on _____. She presented initially to a _____ then to a _____ where she received physical therapy. The patient then presented to her chiropractors, _____ and _____, on or about 5/9/02. Mostly passive physical therapy is provided. An MRI of the left knee performed 6/15/02 suggests medial collateral ligament sprain, edema, and focal cartilage loss and lateral compartment osteophytosis. A physical medicine IME was performed 6/28/02 by _____ suggesting that the patient has post fall contusion with minimal medial collateral ligament sprain.

Full extension and symmetrical flexion is achieved and no additional physical therapy is recommended. Some non-physiological pain symptoms are noted. The patient is referred for orthopedic assessment with _____ and underwent arthroscopic surgery on 9/17/02. Orthopedic reports indicate that the patient has not obtained any significant relief of symptoms with physical therapy and conservative management. Neurodiagnostic study performed 11/7/02 is found essentially normal. Patient continues with chiropractic mobilizations and multiple active and passive modalities. Left knee pain and tenderness appears to continue without measurable resolution. Psychological assessments are obtained suggesting major depression and some psychological overlay. Follow-up evaluations with _____ recommend continued therapy focusing on range of motion and strengthening as well as a home exercise program.

REQUESTED SERVICE (S)

Determine medical necessity for chiropractic services including joint mobilization, therapeutic procedures, neuromuscular re-education, hot or cold pack therapy, myofascial release, office visits, ROM measurements, unusual travel, required reports, telephone conference with patient and muscle testing for dates of service 11/13/02 through 4/2/03.

DECISION

There is medical necessity for therapeutic exercise (97110) for the period 11/13/02 to 4/2/03. This would include office visit evaluation, telephone conference and management services (99212). Periodic ROM and strength testing services (95831 and 95851) also appear reasonable.

This file contains no supporting rationale for reimbursement of unusual travel or for required reports other than DOP for active rehabilitation during the period in dispute 11/13/02 through 4/2/03.

Available documentation did not support medical necessity for 99211 and 99213 services for the period in dispute 11/13/02 through 4/2/03.

However, all passive modality applications including (97265, 97112, 97250, 97010) suggest no clinical utility or potential for further functional restoration.

RATIONALE/BASIS FOR DECISION

There is some reasonable rationale and clinical support for post-operative active rehabilitation concerning these conditions. The available literature suggests no clinical benefit for the management of osteoarthritis and post-surgical pain with the use of these modalities. In addition, the recurring charge for 99082 shows no justification in the available documentation.

1. Tim, KE: "Post-surgical Rehabilitation of the Knee, a five year study of methods" *American Journal of Sports Medicine*, Vol. 16, Issue 5:463-468.
2. Harris GR, Susman JL: "Managing musculoskeletal complaints with rehabilitation therapy" *Journal of Family Practice*, Dec. 2002.
3. Schenck RC: *Athletic Training and Sports Medicine*, AAOS, Rosemont, IL, 1999 (Chapter 16:Knee Injuries, by Shelbourne KD, Rask BP and Hunt S)
4. Calliet R: *Knee Pain and Disability*, 3rd Ed. Pain Series, 1999.
5. *Guidelines for Chiropractic Quality Assurance and Practice Parameters*, Mercy Center Consensus Conference, Aspen Publishers.
6. *Philadelphia Panel Evidence-Based Clinical Practice Guidelines on Selected Rehabilitation Physical Therapy*, Volume 81, Number 10, October 2001.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review.

This review and its findings are based solely on submitted materials. No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned claimant. These opinions rendered do not constitute a per se recommendation for specific claims or administrative functions to be made or enforced.

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) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©)

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) calendar 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 or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 6th day of May 2004.