

MDR Tracking Number: M5-04-0844-01

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 (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on November 19, 2003.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the hot/cold packs, electrical stimulation, therapeutic exercises, group therapy and unusual physician travel were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the treatment listed above were not found to be medically necessary, reimbursement for dates of service from 11-19-02 to 11-22-02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 30th day of January 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division
PR/pr

February 9, 2004

Rosalinda Lopez
Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

REVISED REPORT
Date of injury corrected in "Clinical History"

Re: MDR #: M5-04-0844-01
IRO Certificate No.: 5055

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is Board Certified in Chronic Pain Management.

Clinical History:

A work-related incident resulted in a left knee injury for this claimant on ___. An MRI was performed revealing a meniscal tear. On September 24th, he underwent arthroscopic surgery on the left knee for that problem and was thereafter scheduled for physical rehabilitation. Physical rehabilitation, consisting of passive therapy modalities, commenced on October 3, 2002 and continued for 8 weeks.

Disputed Services:

Hot/cold packs, electrical stimulation, therapeutic exercises, group therapy, unusual physical travel during the period of 11/19/02 through 11/22/02.

Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the treatments and services in dispute as stated above were not medically necessary in this case.

Rationale:

As pointed out in a prior review of this case on 9/10/03, reasonable practices expect a decrease in the implementation of passive modalities and practices with an increase in active participation as the rehab duration continues. Physical therapy notes from 11/19/02 and 11/20/02 document claimant's unimpeded accomplishment of a wide range of physically demanding maneuvers. There is no indication in those notes that objectively substantiates the need for or the necessity of incorporation of passive therapeutic practices at that late stage in the prescribed physical rehab program

Sincerely,