

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

SOAH DOCKET NO: 453-04-6067.M5

MDR Tracking Number: M5-04-1962-01

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. The dispute was received on 3-02-04.

The Medical Review 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 office outpatient visits, therapeutic procedures, therapeutic activities, joint mobilization, myofascial release, kinetic activities, established office visits, unlisted procedures, ultrasound, and electrical stimulation from 3/18/03 through 4/24/03 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 Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service 3/18/03 through 4/24/03 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 4th day of May 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division

RLC/rlc

NOTICE OF INDEPENDENT REVIEW DECISION

Date: April 23, 2004

MDR Tracking #: M5-04-1962-01
IRO Certificate #: 5242

___ 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 proposed 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 Chiropractic physician reviewer who has an ADL certification. The reviewer 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

According to the supplied documentation, it appears that the claimant sustained an injury to his right tibia when a bail of hay weighing approximately 500 lbs fell on him on _____. Plain film x-rays were performed at _____ that revealed a comminuted fracture involving the distal shaft of the right tibia. The claimant underwent an open reduction and internal fixation the following day. Several plain film x-rays were taken following the surgery to monitor the progress of the fracture. The claimant received an 8% impairment on 06/25/2002. The claimant reported to _____ on 01/14/2003 for evaluation. An FCE was performed on 01/15/2003, but did not reveal at what physical capacity the claimant was at. _____ began chiropractic therapy on 01/16/2003. On 04/16/2003, _____ performed a designated doctor exam and assigned a 7% whole person impairment. The documentation ends here.

Requested Service(s)

Please review and address the medical necessity of the outpatient services including office outpatient visits, therapeutic procedure, therapeutic activities, joint mobilization, myofascial release, kinetic activities, established office visits, unlisted procedures, ultrasound and electrical stimulation rendered between 03/18/2003 and 04/24/2003.

Decision

I agree with the insurance company that the services rendered were not medically necessary.

Rationale/Basis for Decision

According to the supplied documentation, the claimant sustained a pilon type fracture that was surgically corrected and monitored for improvement. There appears to be no treatment from 05/2002-01/2003 when the claimant changed treating doctors. At this time of initial evaluation by _____ the claimant would be over _____ post injury. The FCE performed revealed little objective evidence that the claimant needed any additional therapy. According to Trailblazer guidelines, "It is expected that patients undergoing rehabilitation therapy for musculoskeletal injuries in the absence of neurologic compromise will transition to self-directed physical therapy within two months." (www.trailblazerhealth.com) Since the claimant did not appear to have an adequate trial of physical/chiropractic therapy following his surgery then a brief period of care would be indicated. Since the injury was over one year old, then passive and active therapies performed 3 times a week for 4 weeks would have been a reasonable amount of time to reduce the claimant's symptoms. Following the 4 weeks of care, then the claimant would have needed instructions on a proper home-based exercise program that would continue to improve his symptoms without the supervision of a doctor. The dates of service in question begin approximately 8 weeks after the claimant was first evaluated by _____ and are not considered reasonable or medically necessary.