

FORTE

NOTICE OF INDEPENDENT REVIEW DECISION

Date: September 23, 2004

RE:

MDR Tracking #: M5-04-3895-01

IRO Certificate #: 5242

FORTE 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 FORTE for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

FORTE 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 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.

Submitted by Requester:

It should be noted that much of the provided information from the requester was already reviewed as part of the submitted documentation from the carrier, therefore, I will not list all of the documents submitted by the requester. I will list, however, the exceptions.

- Statement of Healthcare Providers Position dated 9/12/04
- Employer's First Report of Injury or Illness dated 6/8/03
- Change of Treating Physician request of 9/5/03 which was filled out by the claimant on 8/14/03
- Team conference call report of 10/2/03 from _____
- TWCC-69 Report of Medical Evaluation from _____ and his report
- TWCC-21 report dated 3/8/04 from the carrier
- TWCC-73 reports from _____ dated 6/9/03 and 6/21/03 as well as 6/30/03
- Voluminous physical therapy notes for approximately 45 visits from 6/9/03 through 10/9/03
- Clinical notations from _____
- FCE of 10/2/03
- List of disputed dates of service

Submitted by Respondent:

- Response to request from IRO for records and overall case review from _____ dated 9/1/04
- Voluminous physical therapy notes from _____ dated 6/9/03 through 10/9/03 for approximately 45 visits
- Employer's First Report of Injury or Illness dated 6/8/03 revealing the claimant's right foot was run over by the driver's side rear tire of a vehicle while she was performing a quality inspection of the vehicle. The claimant was employed as a worker with _____
- _____ note of 6/8/03
- Right foot x-ray report of 6/8/03 revealing there to be a calcaneal spur at the plantar aspect of the right foot – there was no fracture noted
- Initial medical report from _____ dated 6/9/03
- MRI report of the right foot dated 6/24/03
- Peer review report from _____ dated 7/22/03
- TWCC-73 report dated what appears to be 8/1/03 from _____. It appears the claimant changed treating physicians to the _____
- Initial evaluation from the _____ dated 8/6/03. This was mainly a physical therapy evaluation
- Initial foot and ankle consultation report from _____ dated 8/14/03
- Follow up office visit from _____ dated 8/21/03
- Physical therapy progress note of 9/20/03
- Follow up office visit with _____ dated 9/25/03
- FCE of 10/2/03 revealing the claimant to have reached her required physical capacity as required by her employer
- Report of medical evaluation from a designated doctor dated 10/10/03 revealing the claimant to be at MMI on that date with 0% impairment rating. The designated doctor report from _____ was reviewed
- Peer review report from _____ dated 2/26/04
- Some excerpts from the Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters

Clinical History

As has already been reported, the claimant suffered alleged right foot injury when the back left tire of a vehicle driven by a coworker ran over her foot. The claimant did have a tennis shoe on at the time of the injury and did report to an emergency room where there was no evidence of fracture noted. A subsequent MRI evaluation of the right foot was essentially normal with the exception of mild to moderate soft tissue swelling as would be expected. The claimant has seen a podiatrist and has undergone voluminous amounts of physical therapy and was found to be at MMI on or about 10/10/03 with 0% whole body impairment rating.

Requested Service(s)

Level II Office Visit (99212), Therapeutic Exercises (97110), Manual Therapy Techniques (97140), and Neuromuscular Re-Education (97112) from 8/18/03 through 9/30/04. It appears the carrier was billed for an office visit at the 99212 level on every visit during the disputed dates of service. The claimant also underwent 3 fifteen minute sessions of the 97110 procedure as well as 2 sessions of the 97140 procedure. The claimant also underwent 97112 for one unit per visit.

Decision

I agree with the insurance carrier that the services in dispute were not medically necessary.

Rationale/Basis for Decision

All along the claimant's diagnosis has been crush injury to her right foot. The x-rays and the MRI only showed what amounted to soft tissue swelling in an already very obese woman. In fact, one peer reviewer by the name of _____ felt that it should be questioned as to whether or not the claimant's injuries were even serious enough to be classified as a true crush injury. The sequelae were not that representative of crush injury. After all, the claimant could walk on a treadmill for 15 minutes and ride a stationary bike for an additional 15 minutes only one day after the injury occurred. In a true crush injury, the claimant would not likely be able to perform these activities and again the diagnostic work up only showed that of mild to moderate soft tissue swelling which would obviously not need a whole lot of physician directed treatment. The injury was obviously not that severe and a whole gauntlet of physical therapy was thrown at this claimant to the tune of 45 physical therapy visits from 6/9/03 through 10/9/03. This was, in my opinion, not medically necessary and would be considered extremely excessive and not appropriate given the nature and extent of the injury as documented. As documented the claimant underwent anywhere from 1.5–2 hours of therapy on each visit to include the office visit. She underwent approximately 30 minutes of massage, 45 minutes of therapeutic exercises and 15 minutes of neuromuscular re-education along with the 99212 office visit. This would amount to 1.5-2 hours of treatment for this relatively minimal injury. The nature of this particular injury is that it largely heals on its own without high or even moderate levels of physician directed care, treatment or management. In fact the highly evidence based Official Disability Guidelines state the mid-range return to work is only 28 days following this type of injury. The claimant also underwent 27 physical therapy visits **prior** to the disputed dates of service which is quite generous given the documented nature and extent of the injury. The claimant could have easily been transitioned after that amount of treatment into a home based exercise program. This amount of treatment which took place before the disputed dates of service actually exceeds every available evidence based treatment guideline at my disposal.