

MDR Tracking Number: M5-04-3916-01

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 July 15, 2004.

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 97261-manipulation-each additional area, 97014-electrical stimulation-unattended, 97035-ultrasound, 97140-manual therapy technique, 97018-paraffin bath, 97750-MT-muscle testing, 99213-office visit, 97250-myofascial release, 97530-therapeutic activities, G0283-electrical stimulation unattended, 97113-aquatic therapy, 97112-neuromuscular re-education, and 97110-therapeutic exercises from 08-18-03 through 12-08-03 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 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 08-18-03 to 12-08-03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 23rd day of September 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

PR/pr

NOTICE OF INDEPENDENT REVIEW DECISION

Date: September 21, 2004

RE:

MDR Tracking #: M5-04-3916-01

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 reviewer (who is board certified in) 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:

- Correspondence Letter dated 8/30/04 from _____, _____
- Narrative Report dated 7/28/04 from _____
- MRI Report of the left ankle dated 7/15/04 from _____
- Daily Progress Notes dates 8/18/03-12/8/03
- Range of Motion and Muscle Testing of the Upper and Lower Extremity dated 8/25/03, 10/20/03 and 2/5/04
- Occupational Therapy Evaluation of Lower Extremity dated 9/15/03
- Treatment Summary dated 10/17/03, 11/18/03 and 12/15/03
- Re-Exam Narrative dated 3/29/04

Submitted by Respondent:

- Table of Disputed Services dates 8/18/03-12/8/03
- Explanation of Benefits from _____ dates 8/18/03-12/8/03

Clinical History

I have had the opportunity to review the medical records in the above-mentioned case for the purpose of an Independent Review. The claimant twisted his left ankle ___ when he stepped into a ditch while at work. _____ who recommended physiotherapy modalities, joint mobilization and soft tissue mobilization with progression to active physical therapy, initially saw the claimant on 6/28/03. The claimant had a MRI of the left ankle performed on 7/15/03 at _____, which revealed partial tear and/or tenosynovitis of the peroneus tendons and posterior tibial tendon, tenosynovitis of the flexor hallucis tendon and sprain and /or soft tissue swelling of the ankle. The claimant participated in Occupational Therapy under the direction of _____. The claimant's treatment with the claimant included interferential current, therapeutic exercise and neuromuscular re-education. The claimant has had approximately 26 office visit from _____ based on the provided medical documentation. _____ who determined the claimant at maximum medical improvement last saw the claimant on 3/29/04.

Requested Service(s)

97261-Manipulation-each additional area, 97014 electrical stimulation-unattended, 97035 ultrasound, 97140- manual therapy technique, 97018-paraffin bath, 97750-MT- muscle testing, 99213-Office Visit, 97250-myofascial release, 97530-therapeutic activities, G0283-electrical stimulation unattended, 97113-aquatic therapy, 97112-neuromuscular reeducation, 97110 therapeutic exercises for dates of service 8/18/03-12/08/03.

Decision

I agree with the insurance carrier and find that 97261-Manipulation-each additional area, 97014 electrical stimulation-unattended, 97035 ultrasound, 97140- manual therapy technique, 97018-paraffin bath, 97750-MT- muscle testing, 99213-Office Visit, 97250-myofascial release, 97530-therapeutic activities, G0283-electrical stimulation unattended, 97113-aquatic therapy, 97112-neuromuscular reeducation, 97110 therapeutic exercises are not medically reasonable and necessary for the disputed dates listed above.

Rationale/Basis for Decision

I form this decision using the Official Disability Guidelines 8th Edition which allows up to 9 chiropractic treatment/physical therapy treatments over an 8 week period with a gradual fade of treatment frequency plus an active self-directed home therapy program for left ankle sprain/strain. The objective findings of _____ are consistent with a left ankle sprain/strain and the description of ankle sprain/strain given in the Official Disability Guidelines 8th Edition which is: "Injury to the ligament (sprain) or to the muscle (strain) of the ankle. Sprain and strains are usually accompanied by tearing of the tissue as well as symptoms of pain, limited motion, swelling, bruising, and/or a change in sensation." The Official Disability Guideline 8th Edition is a guideline of specific conditions which uses a many major sources one being the "Mercy Guidelines", the consensus document created by the American Chiropractic Association in conjunction with the Congress of State Chiropractic Associations, entitled Guidelines for Chiropractic Quality Assurance and Practice Parameters, Proceedings of the Mercy Center Consensus Conference. It is from these Guidelines I form my decision for the above reference claimant.

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 patient, the requestor, the insurance carrier, and TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 21st day of September 2004.