

**MDR Tracking Number: M5-04-4005-01**

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 22, 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 electrical stimulation, therapeutic exercises, and manual therapy technique 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 was the only issue** to be resolved. As the treatment electrical stimulation, therapeutic exercises, and manual therapy technique were not found to be medically necessary, reimbursement for dates of service from 10/23/03 thru 12/9/03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 8<sup>th</sup> day of October 2004.

Margaret Q. Ojeda  
Medical Dispute Resolution Officer  
Medical Review Division

MQO/mqo

**NOTICE OF INDEPENDENT REVIEW DECISION**

**Date:** September 23, 2004

**RE:**

**MDR Tracking #:** M5-04-4005-01

**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 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:**

- Multiple requests for reconsideration of bills
- MRI of the right ankle
- Evaluation notes from \_\_\_\_\_
- Progress notes from \_\_\_\_\_
- Notes from \_\_\_\_\_
- Designated doctor exam from \_\_\_\_\_
- Disputed explanation of benefits

**Submitted by Respondent:**

- No documentation was submitted by the respondent

**Clinical History**

According to the supplied documentation it appears the claimant sustained an injury to her back, right knee, right ankle and left knee when she slipped on \_\_\_\_\_. The claimant went through conservative therapy consisting of physical therapy as well as chiropractic treatment. It appears the claimant underwent 3 steroid injections; however, no reports were submitted for review. An MRI was performed on 9/29/03 which revealed a complete disruption of the peroneal tendons laterally with presumed retraction. The report also states that the finding appears to involve the peroneus brevis tendon as described. A 4mm inferior calcaneal spur and degenerative changes were noted. Documentation from \_\_\_\_\_ reported the claimant was being treated with medications but that a surgical procedure would more than likely be necessary. On 11/7/03 the claimant was seen by \_\_\_\_\_ for a designated doctor evaluation. \_\_\_\_\_ reported the claimant was not at MMI and was planning on undergoing right heel surgery. The documentation ends here.

**Requested Service(s)**

Electrical stimulation, therapeutic exercises, manual therapy technique from 10/23/03 to 12/9/03

**Decision**

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

**Rationale/Basis for Decision**

According to the supplied documentation, on 9/29/03 the claimant underwent an MRI to her right ankle which revealed a complete disruption of one of the peroneal tendons laterally and involvement of the peroneus brevis as well. The dates of service in question from 10/23/03 through 12/9/03 include manual therapy and therapeutic exercises which would be contraindicated in the treatment of a complete disruption of one of the peroneal tendons. No future active therapy would be considered reasonable or medically necessary beyond the 9/29/03 findings of the MRI reports. (Once operation is accomplished, appropriate rehabilitation would be in order.) Since the onset of the dates of service in question is approximately 3 weeks post MRI, it would be considered unreasonable to continue active

therapies which would further induce complications of the compensable injury. No documentation was supplied to objectively support the treatment rendered during the dates of service in question.