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

SOAH DOCKET NO. 453-05-1695.M5

MDR Tracking Number: M5-04-4041-01

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 7-23-04.

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 visits, therapeutic procedures, electrical stimulation-unattended, ultrasound, manual therapy techniques, hot-cold pack therapy, myofascial release, therapeutic procedure-ROM-15 min., application of a modality-electrical stimulation-15 minutes from 7-11-03 through 4-7-04- were not medically necessary.

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 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 22nd day of September 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division
DA/da

September 17, 2004

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

REVISED REPORT
Corrected services in dispute.

Re: Medical Dispute Resolution
MDR #: M5-04-4041-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: 5055

Dear

___ 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.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:
TWCC-60, Table of Disputed Services, EOB's
Information provided by Requestor:

- letter of medical necessity 08/23/04
- progress notes 06/05/02 – 07/21/03
- daily S.O.A.P. notes 05/05/03 – 04/07/04
- radiology: MRI Hand 05/14/04, MRI Lumbar Spine 09/30/02, MRI Right Knee 07/19/02, Views Cervical & Lumbar Spine 07/05/02,

Information provided by Respondent:

- letter to IRO 08/20/04
- RME 12/09/02

Information provided by Orthopedic Surgeon:

- orthopedic Reports 10/08, 04/15, 03/04, 01/21, 01/07/2003, 12/23, 11/21, 10/17, 09/12, 08/15/2002
- orthopedic letter of medical necessity 04/30/03
- operative report 01/10/03

Clinical History:
On ___, this claimant was injured while on her job. She was taken by ambulance to a hospital.

Disputed Services:
Office visits-established patient-15 min., OV-established patient-10 min., OV-established patient-25 min., therapeutic procedure, electrical stimulation-unattended, ultrasound, manual therapy techniques, hot/cold pack therapy, myofascial release, therapeutic procedure, ROM-15 min., application of a modality electrical stimulation-15 min., during the period of 07/11/03 through 04/07/04.

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

Rationale:
The treatment that was given to this patient through the date of the knee MRI on 7/19/02, and the lumbar MRI on 09/30/02, were valid. All manual therapy techniques and all therapeutic procedures were valid up through the date of the right knee MRI. Treatment should have been suspended on that area pending the orthopedic referral report, in which arthroscopic surgery to the knee was recommended. Following surgery a rehab phase I and phase II to that area in, conjunction with the other body parts from this injury would have been valid.

Any treatment beyond the dates of the MRI's really show no documentation of any continuing improvement in any objective measures for range of motion, strength, or function that would justify the therapy. Normally, as therapy progresses, there should be a decrease in the frequency and intensity of therapy and a gradual transition to a home program. Normal physical therapy can be a reasonable part of a rehabilitation program following an injury and procedure, but there must be some demonstrative benefit to the therapy in order to establish medical necessity. Even according to the Mercy Guidelines, after a maximum of 4 weeks of manual procedure without significant documented improvement, continuing treatment may not be appropriate, but alternative care should be considered.

Sincerely,