

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 11-15-04.

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 exercises, manual therapy techniques, neuromuscular re-education and electrical stimulation 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 from 03-03-04 to 03-29-04 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Findings and Decision is hereby issued this 31<sup>st</sup> day of January 2005.

Debra L. Hewitt  
Medical Dispute Resolution Officer  
Medical Review Division

DLH/dlh

Enclosure: IRO decision

**IRO Medical Dispute Resolution M5 Retrospective Medical Necessity  
IRO Decision Notification Letter**

Date: 1/31/2005  
Injured Employee:  
MDR : M5-05-0876-01  
TWCC #:  
MCMC Certification #: 5294

**DETERMINATION: Deny**

Requested Services:

Please review the following items in dispute: Were the office visits (99212, 99213), therapeutic exercises (97110), manual therapy techniques (97140), neuromuscular re-education (97112), electrical stimulation (97032) on 03/03/2004 to 03/29/2004 medically necessary?

MCMC llc (MCMC) is an Independent Review Organization (IRO) that was selected by The Texas Workers' Compensation Commission to render a recommendation regarding the medical necessity of the above Requested Service.

Please be advised that a MCMC Physician Advisor has determined that your request for M5 Retrospective Medical Dispute Resolution on 12/08/2004, concerning the medical necessity of the above referenced requested service, hereby finds the following:

The medical necessity for the list of services captioned above is not established upon review of the documentation.

This decision is based on:

- TWCC Notification of IRO Assignment dated 12/8/2004
- TWCC MR-117 dated 12/8/2004
- TWCC-60 stamped received 11/15/2004 4 pgs
- Liberty Mutual Explanation of Benefits for dates of service (DOS) 3/3/2004 to 3/29/2004 10 pgs
- W9 form dated 5/26/2004
- 2310, LLC DBA Complete Health & Rehab Request for Medical Dispute Resolution dated 12/7/2004 4 pgs, Medical Necessity letter dated 7/9/2004 2 pgs; Response to Designated Doctor Report dated 5/28/2004 2 pgs; Office Notes dated 1/13/2004 to 6/22/2004 56 pgs
- Professional Reviews, Inc. Review dated 3/17/2004 2 pgs, Reconsideration dated 8/10/2004 3 pgs
- Churchill Evaluation Centers Report of Medical Evaluation dated 5/12/2004 2 pgs
- North Houston Imaging Center MRI of left knee report dated 1/30/2004

Records indicate that the above captioned individual, a 59-year-old female, was allegedly injured as a result of an occupational injury that occurred on or about \_\_\_ as she was climbing a ladder and struck her left knee on a protruding rod. Records further indicate that the injured individual sought care under the administration of the Attending Provider (AP), Dr. Oistad, who initiated a course of chiropractic management. An MRI performed on 01/30/2004 of the left knee revealed joint effusion, mild tendonitis of the posterior cruciate ligament, mild tenosynovitis and tendinosis of the lateral collateral ligament, mild to moderate degenerative joint disease of the knee joint with Grade I chondromalacia patella, other specific degenerative changes with no tearing and otherwise unremarkable MRI of the left knee. Treatment has consisted of passive and active rehab and a short course of aquatic therapy. Functional Capacity Evaluations (FCE) were performed on 04/27/2004 and 06/22/2004, which revealed decreased ranges of motion of the right knee and some lifting functional deficits.

The documentation fails to establish the medical necessity for the continuation of chiropractic care inclusive of the list of services referenced above. Specifically, this claimant was injured as a result of an occupational injury, which allegedly occurred on \_\_\_. Chiropractic care was initiated on 01/13/2004. Given the fact that by 03/03/2004, six weeks of conservative chiropractic care had been administered, the medical necessity for additional chiropractic care would need to be substantiated by a review of the documentation, which should show objective progress. It would appear

from a review of the documentation submitted that some subjective progress was achieved from 01/13/2004 through 03/03/2004, however there is no objective comparative data from which to ascertain if clearly defined objective progress was being documented. Furthermore, there is no initial objective exam submitted for review from which to develop a baseline of objective data from which to later compare to ascertain if progress is being achieved. Similarly, there are no follow-up objective exams to clearly document that objective progress was being achieved. The daily documentation consists of check-off sheets which make anecdotal references to current symptomatology and interruption of activities of daily living, however there is no standard comparative objective data from which to ascertain if progress was being achieved through the initial course of care, and therefore substantiate the need for additional similar intervention.

Given the lack of clearly defined comparative objective data, the medical necessity of the listed medical services captioned above is not established.

The reviewing provider is a Licensed Chiropractor and certifies that no known conflict of interest exists between the reviewing **Chiropractor** and any of the treating providers or any providers who reviewed the case for determination prior to referral to the IRO. The reviewing physician is on TWCC's Approved Doctor List.

This decision by MCMC is deemed to be a Commission decision and order (133.308(p) (5)).

**In accordance with commission rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent via facsimile to the office of TWCC on this**

**31<sup>st</sup> day of January 2005.**

**Signature of IRO Employee:** \_\_\_\_\_

**Printed Name of IRO Employee:** \_\_\_\_\_