

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 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 Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(q)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

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. The “water circulating unit, cold therapy cooler wrap and water circulating pad” were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the “water circulating unit, cold therapy cooler wrap and water circulating pad” charges.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby **ORDERS** the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to date of service 10/5/02 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 27 day of June 2002.

Medical Dispute Resolution Officer
Medical Review Division

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and subsequently re-delegated by Virginia May, Deputy Executive Director.

June 23, 2008

Texas Workers' Compensation Commission
Medical Dispute Resolution
4000 South IH-35, MS 48
Austin, TX 78704-7491

Re: Medical Dispute Resolution MDR #: M5-02-2099-01

Dear Ms.

IRI has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a Doctor of Chiropractic Medicine.

THE REVIEWER OF THIS CASE DISAGREES WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER. The requested water circulating unit, cold therapy cooler wrap and water circulating pad were medically necessary.

I am the Secretary and General Counsel of Independent Review, Inc. 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.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted.

Sincerely,

Gilbert Prud'homme
Secretary & General Counsel
GP:mbs
Enclosure (1)

MEDICAL CASE REVIEW

This is for Independent Review Incorporated, 1601 Rio Grande, Suite 420, Austin, Texas 78701. I have reviewed the medical information forwarded to me concerning TWCC Case File #M5-02-2099-01, in the area of Chiropractic. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Request for review of denial of water circulating unit, cold therapy cooler wrap, and water circulating pad.
2. Correspondence of Nick Cianelli, D.C. from 11/16/01 and letter of necessity, 04/29/02, letter from Anne E. McCollough from Baron Risk Management, and Kevin Tomsic, D.C. TWCC-69 from 11/06/01.
3. Office notes from Nick Cianelli, D.C. from 08/29/01 through 04/01/02.
4. Operative report from James Laughlin, D.O., F.A.C.O.S., dated 12/13/01.

5. Concentra treatment records.
6. Imaging records from Lone Star MRI, 09/21/01.
7. Surgical pre-authorization approval notice, 11/07/01.

B. SUMMARY OF EVENTS:

This patient was involved in a work-related accident on 08/11/01 while she was working for the Fort Worth Transportation Authority. The claimant states that "she injured herself when turning the steering wheel."

The patient was diagnosed with a shoulder strain/sprain by a Concentra physician and then again on 08/24/01 by Dr. Nick Cianelli.

The patient received a right shoulder MR imaging on 09/21/01 that confirmed the evidence of supraspinatus tear, bicipital tendinitis, and labral tear.

On 10/05/01, a request for DME (water circulating unit, cold therapy cooler wrap, and water circulating pad) was submitted by OxyMed.

The request was denied due to lack of medical necessity on 11/30/01 and on 01/15/02.

C. OPINION:

1. I DISAGREE WITH THE DETERMINATION MADE BY THE UTILIZATION REVIEW AGENT ON THIS CASE ABOUT THE ISSUE OF MEDICAL NECESSITY OF THE DME PRODUCTS AT THE TIME OF REQUEST.
2. It is the opinion of this reviewer that sufficient documentation of injury (09/21/01 MR imaging of right shoulder) existed to show medical necessity for the 10/05/01 requested DME.
3. A shoulder strain/sprain diagnosis does include tear of the musculature. A muscular tear responds in a favorable manner to cryotherapy and shows medical necessity for the request.
4. On 09/21/01, the patient underwent MR imaging of the right shoulder that showed a supraspinatus tear, bicipital tendinitis, and a labral tear.
5. Prior to denial of the first request of DME on 11/30/01, a referral was made to a shoulder orthopedic surgeon who confirmed a tear of the supraspinatus musculature and impingement of the right shoulder on 11/02/01. Surgical approval was given on 11/07/01.
6. Screening criteria utilized take reference with extracted Delphi Rehabilitation Protocols of the American Chiropractic Rehabilitation Board, protocols for Physical Medicine and Rehabilitation, supporting clinical documentation, and practice experience.

D. ADDITIONAL COMMENTS:

It is the opinion of this reviewer that the insurance carrier knew that the patient was going to have surgery, because it was approved on 11/07/01 and thus should have processed the request for the DME as a medically necessitated event.

Basing a decision of medical necessity solely upon an ICD-9 code is not a sound medical practice. Medical necessity should be determined from the patient's total clinical presentation that should include diagnostic testing, referrals, and current treatment plan.

E. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

Date: 25 June 2002