

MDR Tracking Number: M5-04-0190-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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. This dispute was received on 9-15-03.

The IRO reviewed joint mobilization and therapeutic activities from 5-2-03 through 5-21-03.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of 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.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 12-9-03, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The requestor failed to submit relevant information to support the fee component in accordance with Rule 133.307(g)(3)(A-F). No reimbursement recommended.

The above Findings and Decision is hereby issued this 27th day of February 2004.

Dee Torres
Medical Dispute Resolution Officer
Medical Review Division
February 24, 2004

**NOTICE OF INDEPENDENT REVIEW DECISION
Amended Determination C**

RE: MDR Tracking #: M5-04-0190-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in physical medicine and rehabilitation. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 40 year-old male who sustained a work related injury on ___. The patient reported that while at work he fell from a scaffold hitting his right shoulder on a rail. The patient underwent shoulder and scapular X-Rays. The patient also underwent an MRI of the right shoulder on 1/10/03 that showed an apparent bone bruise in the medial aspect of the proximal humeral head and neck. The diagnoses for this patient include complete rupture of rotator cuff, AC joint sprain and derangement of joint, shoulder. Treatment for this patient's condition has included physical therapy, chiropractic treatment and work hardening.

Requested Services

Joint mobilization and therapeutic activities from 5/2/03 through 5/21/03

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is upheld.

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 40 year-old male who sustained a work related injury to his right shoulder on ___. The ___ physician reviewer indicated that this patient has been treated with physical therapy consisting of joint mobilization, myofascial release and exercises from late 12/02 through 5/21/03. The ___ physician reviewer noted that the patient's pain level has remained 5-6/10 consistently in physical therapy notes. The ___ physician reviewer also noted that a progress note dated 4/20/03 indicates that the patient continues to have weakness and mild to moderate limitations in range of motion of the right shoulder. The ___ physician reviewer explained that the patient had plateaued in physical therapy and was not showing significant gains or progress in functional range of motion or reduction in pain/discomfort level. Therefore, the ___ physician consultant concluded that the joint mobilization and therapeutic activities from 5/2/03 through 5/21/03 were not medically necessary to treat this patient's condition.

Sincerely,