

MDR Tracking Number: M5-04-0249-01

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 9-22-03.

The IRO reviewed therapeutic exercises and office visits from 11-25-02 through 11-27-02.

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 12-1-03, 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 components of the fee dispute in accordance with Rule 133.307(g)(3)(A-F). No reimbursement recommended.

This Decision is hereby issued this 2nd day of March 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

November 26, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-0249-01

___ 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 orthopedic surgery. 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 49 year-old male who sustained a work related injury on ___. The patient reported that while at work he fell from a frame machine on to a concrete floor injuring his right arm and shoulder. The patient was evaluated in the emergency room where he was initially diagnosed with a right triceps rupture and treated with oral pain medications and a splint. The patient was then evaluated by an orthopedic surgeon and diagnosed with a right humerus osteochondroma and right arm contusion. He was treated with physical therapy and a work hardening program and was returned to work. The patient reported increased pain of the right shoulder and arm and was then diagnosed with recurrent pain of right shoulder/arm with suspected injury to right biceps and lateral epicondyle and neuropathy. The patient was then treated with physical therapy and medications. The patient underwent an EMG/NCV on 5/6/02 and an MRI on 5/10/02. On 8/13/02 the patient underwent right shoulder arthroscopy with subacromial decompression, debridement of partial rotator cuff and anterior labral tears and placement of a pain pump. Postoperatively the patient was treated with physical therapy.

Requested Services

Subsequent visit and exercises from 11/25/02 through 11/27/02.

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 49 year-old male who sustained a work related injury to his right arm and shoulder on ___. The ___ physician reviewer also noted that the on 8/13/02 the patient underwent right shoulder arthroscopy with subacromial decompression, debridement of partial rotator cuff and anterior labral tears and placement of a pain pump. The ___ physician reviewer further noted that postoperatively the patient was treated with physical therapy. The ___ physician reviewer indicated that the services in dispute took place more than three months after the surgery on 8/13/02. The ___ physician reviewer explained that the services on 11/25/02 through 11/27/02 did not contribute to this patient's functional outcome. Therefore, the ___ physician consultant concluded that the subsequent visit and exercises from 11/25/02 through 11/27/02 were not medically necessary to treat this patient's condition.

Sincerely,