

MDR Tracking Number: M5-04-0374-01

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 (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 October 7, 2003.

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(r)(9), the Commission hereby Orders the respondent and non-prevailing party to **refund the requestor \$460** for the paid IRO fee. For the purposes of determining compliance with the Order, the Commission will add 20-days to the date the Order was deemed received as outlined on page one of this Order.

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 office visits; electrical stimulation, and subsequent visits were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

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 dates of service 02/11/03 through 07/21/03 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 19th day of December 2003.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division
PNR/pnr

NOTICE OF INDEPENDENT REVIEW DECISION

December 10, 2003

MDR Tracking #: M5-04-0374-01
IRO Certificate #: IRO 4326

The ___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___'s health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient sustained injuries to his right shoulder, neck, and low back on ___ when he was in a motor vehicle accident. A cervical MRI performed on 12/07/01 revealed disc protrusion at C3-4 with compression of the spinal cord and had a discectomy, laminectomy, and fusion in 2002. He had a second right shoulder MRI on 05/14/03, which revealed a full thickness tear of the rotator cuff. He had been seeing a chiropractor for treatment and therapy.

Requested Service(s)

Office visits, electrical stimulation, and subsequent visits from 02/11/03 through 07/21/03

Decision

It is determined that the office visits, electrical stimulation, and subsequent visits from 02/11/03 through 07/21/03 were medically necessary to treat this patient's condition.

Rationale/Basis for Decision

After the results were obtained from the second right shoulder MRI, a surgery consult was obtained. A lumbar MRI revealed a problem and the specialist recommended epidural steroid injections and possible lumbar surgical intervention. A functional capacity evaluation (FCE) revealed the patient had limitations to returning to his heavy job classification. The treating physician saw the patient for a trial of care while additional testing and consultations were scheduled.

This is a complicated case in the fact that there were multiple areas of injury and even after cervical surgery, problems continued. The office notes, diagnostic testing results, and specialist reports clearly indicate the severity of his injuries and justify treatment the he received. Therefore, it is determined that the office visits, electrical stimulation, and subsequent visits from 02/11/03 through 07/21/03 were medically necessary.

Sincerely,