

MDR Tracking Number: M5-04-0680-01

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 31, 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 \$460.00** 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, therapeutic exercises, neuromuscular reeducation, and office visits (established patient) were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

This findings and decision is hereby issued this 20th day of February 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

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 11/18/02 through 01/10/03 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 20th day of February 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division
RL/pr

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

February 16, 2004

Re: IRO Case # M5-04-0680-01

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Orthopedic Surgery, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting 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 referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient is a 20-year-old male who in ____ fell onto the left shoulder, suffering a large rotator cuff tear as well as an injury to his left knee and neck. The patient's left knee and neck improved with rehabilitation, but his left shoulder did not. The patient underwent a left shoulder acromioplasty, rotator cuff repair, and distal clavicle excision on 8/16/02. Postoperative physical therapy began on 9/6/02 and continued through January 2003.

Requested Service(s)

Office visit, therapeutic exercises, neuromuscular re education, office visits (established patient) 11/18/02 – 1/10/03

Decision

I disagree with the carrier's decision to deny the requested services.

Rationale

The patient suffered a very large, retracted rotator cuff tear as well as an injury to the cervical spine and knee. Three to four months of physical therapy with modalities is reasonable for this patient's injury. The medical documentation provided for this review demonstrates slow progress and a good response to physical therapy, which is to be expected for someone who requires an open rotator cuff repair. Physical therapy aimed at improving this patient's range of motion, decreasing pain, and increasing his functional status is well documented and indicates that the treatment was medically necessary.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.