

MDR Tracking Number: M5-04-0689-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 11-03-03.

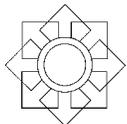
The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the therapeutic exercises/procedures, hot/cold pack therapy, office visits, mechanical traction, supplies and materials, joint mobilization and physical medicine procedure on 11/05/02 through 01/08/03 were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service 11/05/02 through 01/08/03 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 13th day of January 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh
Enclosure: IRO decision



Texas Medical Foundation

Barton Oaks Plaza Two, Suite 200 • 901 Mopac Expressway South •
Austin, Texas 78746-5799
phone 512-329-6610 • fax 512-327-7159 • www.tmf.org

NOTICE OF INDEPENDENT REVIEW DECISION

January 8, 2004

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker: _____
MDR Tracking #: M5-04-0689-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) 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 TMF for independent review in accordance with TWCC §133.308 which allows for medical dispute resolution by an IRO.

TMF 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 TMF physician reviewer who is board certified in orthopedic surgery which is the same specialty as the treating physician. The TMF physician reviewer 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 TMF 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 an injury on ____ while descending a ladder, fell and landed on her right arm, head, and low back. A right shoulder MRI dated 08/02/02 revealed impingement upon the anterior musculotendinous junction and acromioclavicular arthritis. She attended physical therapy and eventually underwent right shoulder arthroscopic surgery on 06/23/03.

Requested Service(s)

Therapeutic exercises/procedures, hot/cold pack therapy, office visits, mechanical traction, supplies and materials, joint mobilization, and physical medicine procedure from 11/05/02 through 01/08/03

Decision

It is determined that the therapeutic exercises/procedures, hot/cold pack therapy, office visits, mechanical traction, supplies and materials, joint mobilization, and physical medicine procedure from 11/05/02 through 01/08/03 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient has had adequate physical therapy for the treatment of her right shoulder from 09/12/02 through 11/07/02. The therapy after that point would have been done on a home basis without the need for a formal therapy session. With appropriate therapy, it is expected that the patient would show improvement within the first eight to ten weeks. The medical record documentation indicates that the patient had no sign of atrophy, decreased range of motion, or decrease in strength demonstrated prior to therapy and therefore does not support the need for continuance of therapy. The records state that she was the same on 09/12/02, 10/10/02, 11/07/02, and 01/03/03. There was no demonstrated cervical pathology by exam, x-ray, MRI, or special studies. Therefore, it is determined that the therapeutic exercises/procedures, hot/cold pack therapy, office visits, mechanical traction, supplies and materials, joint mobilization, and physical medicine procedure from 11/05/02 through 01/08/03 were not medically necessary.

Sincerely,

A handwritten signature in black ink, appearing to read "Gordon B. Strom, Jr.", written in a cursive style.

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:vn