

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 November 13, 2003.

The 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, group therapy and office visits 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 Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the treatments listed above were not found to be medically necessary, reimbursement for dates of service from 11-13-02 to 12-30-02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 23rd day of January 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division
PR/pr

NOTICE OF INDEPENDENT REVIEW DECISION

Date: January 16, 2004

RE: MDR Tracking #: M5-04-0783-01
IRO Certificate #: 5242

___ 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 proposed 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 an Orthopedic Surgeon reviewer (who is board certified in Orthopedic Surgery) who has an ADL certification. The 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 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

The claimant has a history of chronic neck and left shoulder pain allegedly related to a compensable work injury on _____. The claimant was allegedly carrying pipes over the left shoulder and had onset of neck and shoulder pain. The claimant was managed conservatively with physical therapy and work hardening and returned to work as a dispatcher.

Requested Service(s)

Therapeutic exercises, group therapy, office visits from 11/13/02 - 12/30/02

Decision

I agree with the insurance carrier and find that the services in dispute are not medically necessary.

Rationale/Basis for Decision

Generally supervised physical therapy is indicated following acute injury or a post operative condition to initiate range of motion and to facilitate regaining muscle strength. Supervised physical therapy is generally not indicated for chronic pain conditions when the pain generator site is of uncertain etiology, particularly when there is no evidence of injury or aggravation of pre-existing condition. The claimant has a history of chronic shoulder and neck pain. There is no documentation of specific pain generator site. The goals of physical therapy according to a clinic note dated 11/11/03 were to instruct the claimant in a home exercise program, to increase left shoulder range of motion, to increase cervical range of motion, to improve strength of the left upper extremity, to decrease pain complaints, and to increase cardiovascular fitness. The claimant completed 6 authorized sessions of physical therapy. There is no clear explanation why a well controlled home exercise program and conventional ice/heat modalities would be any less effective than continued supervised physical therapy, beyond the authorized 6 visits, in this clinical setting.