MDR Tracking Number: M5-04-0853-01

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 November 20, 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 procedures, group therapeutic procedures, office visits, physical medicine treatment 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 12-27-02 to 03-24-03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 20th day of February 2004.

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

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

February 16, 2004

Re: IRO Case # M5-04-0853-01

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 32-year-old female who reported a repetitive shoulder injury to her left shoulder ___. She was evaluated and treated, and physical therapy was started on 10/28/02. From October 2002 until March 2003 the patient received approximately 27 physical therapy sessions. The medical records document poor patient compliance with her physical therapy, and 12 physical therapy visits were deemed medically necessary for this patient's condition by a peer reviewer.

Requested Service(s)

Therapeutic procs, grp ther procs, ovs, phys med tx 12/27/02-3/24/03

Decision

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

Rationale

Based on the records provided for this review, the patient appears to have rotator cuff tendonitis with no evidence of objective pathology on her MRI examination. Rotator cuff tendonitis/impingement syndrome responds well to approximately four weeks of physical therapy, followed by a patient controlled home exercise program. Physical therapy beyond this four weeks, or 12 visits, is not deemed medically

> necessary unless the patient is to proceed with more interventional procedures such as subacromial steroid injection. A short course of post injection therapy, 4 visits, might then be indicated.
>
> However, this patient did not receive such an injection, and continued therapy was excessive. The records provided do not document adequate indications for continued physical therapy, and indicate poor patient compliance, which is not an indication for continued physical therapy.

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