

MDR Tracking Number: M5-04-1234-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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. This dispute was received on 1-5-04.

The IRO reviewed therapeutic exercises, joint mobilization, ultrasound, myofascial release, office visits, mechanical traction, neuromuscular re-education, and massage from 2-10-03 to 11-21-03.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. The IRO concluded that the ultrasound, myofascial release, therapeutic exercises, office visits, and joint mobilization from 2-10-03 to 4-21-03 were medically necessary. The IRO agreed with the previous adverse determination that the office visits, mechanical traction, myofascial release, therapeutic exercises, manual therapy, massage, chiropractic manipulation, ultrasound, and self-care/home management training were not medically necessary from 5-2-03 to 11-21-03. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 3-12-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice. The requestor failed to submit relevant information to support components of the fee dispute. Therefore, no review can be conducted and no reimbursement recommended for the fee component.

This Decision is hereby issued this 17th day of June 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for 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 for dates of service 2-10-03 through 4-21-03 in this dispute.

This Order is hereby issued this 17th day of June 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

March 8, 2004

Amended March 11, 2004

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IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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 care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Chiropractic. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

CLINICAL HISTORY

On 1/6/03, ___ underwent shoulder surgery and post-operative rehabilitation after injuring himself on ___ while pushing a 700-pound piece of equipment.

DISPUTED SERVICES

Under dispute is the medical necessity of therapeutic exercises, joint mobilization, ultrasound therapy, myofascial release, office visits, office visits est. patient e/m, mechanical traction, neuromuscular re-education and massage therapy. Note: manual therapy, chiropractic manipulative treatment, and self-care/home management training one-on-one fall under the Medicare Guidelines for services on or after 8/1/03.

DECISION

The reviewer disagrees with the prior adverse determination for all care from 1/27/03 through 4/21/03.

The reviewer agrees with the prior adverse determination for all care provided from 4/22/03 forward.

BASIS FOR THE DECISION

Ninety days (1/27/03 through 4/21/03) of post-operative rehabilitation was both indicated and medically necessary after the shoulder surgery. This opinion is even supported by the carrier's reviewer (2/3/03, page 2) who opined that if the patient underwent surgery, he "would be afforded post op rehab" consisting of "visits/therapy/rehab" that be expected to last for "some 90 days."

However, the records fail to support the medical necessity of additional care after 4/21/03. In fact, the treatment records during the entire treatment period fail to objectively measure the patient's response to care by documenting gains in pain reduction, functional improvement or the ability of the patient to return to work. Moreover, the records do not document any complicating factors that would in any way substantiate the need for additional care.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy

As an officer of ___, Inc, dba ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,