

MDR Tracking Number: M5-04-1476-01

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 1-13-04.

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** 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 electrical stimulation (other than wound), massage therapy, ultrasound therapy, and therapeutic activities were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed service.

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 11/14/03 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 Decision and Order is hereby issued this 6th day of April 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division

RLC/rlc

NOTICE OF INDEPENDENT REVIEW DECISION

March 30, 2004

MDR Tracking #: M5-04-1476-01
IRO Certificate #:IRO4326

The ___ 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 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 matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___'S health care professional 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

This patient sustained an injury on ___ when he slipped off a chair and hit his left elbow on a cement floor. He saw a chiropractor for treatment and therapy. He was referred to an orthopedic surgeon who performed an excision of the olecranon bursa on 09/08/03. After release from the surgeon, he began post operative therapy.

Requested Service(s)

Electrical stimulation other than wound, massage therapy, ultrasound therapy, and therapeutic activities on 11/14/03

Decision

It is determined that the electrical stimulation other than wound, massage therapy, ultrasound therapy, and therapeutic activities on 11/14/03 were medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The examination and treatment records document the medical necessity of the treatment performed on the date in question. The patient's pain rating gradually progressively decreased from "10" at the initiation of care to "5" (on the last two treatment dates on 11/12/03 and 11/14/03). Between these last two dates, a 17% decrease in pain was noted. More importantly, the care in question relieved the effects of the compensable injury and was thus medically necessary. Therefore, it is determined that the electrical stimulation other than wound, massage therapy, ultrasound therapy, and therapeutic activities on 11/14/03 were medically necessary.

Sincerely,