

THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:
SOAH DOCKET NO. 453-04-7156.M5

MDR Tracking Number: M5-04-1937-01

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 03-01-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the majority of 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 work hardening/conditioning (initial and additional hours), functional capacity evaluation, office visit, conductive paste, neuromuscular stimulation, and electric shock unit from 4/18/03 through 6/04/03 **were found** to be medically necessary. The office visit dated 8/21/03 **was not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

This Findings and Decision is hereby issued this 26th day of May 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division

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 through 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 Order is hereby issued this 26th day of May 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/rlc

May 7, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-1937-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in physical medicine and rehabilitation and is familiar with the condition and treatment options at issue in this appeal. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians

or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a female who sustained a work related injury on ___. The patient reported that while at work she was lifting boxes when she injured her right shoulder. A MRI of the right shoulder was reported to have shown acromioclavicular joint arthritis, with minimal impingement upon the supraspinatus muscle. A CT of the right shoulder dated 5/22/02 was reported as showing AC spurring, subacromial spurring and Type II acromion. On 7/18/02 the patient underwent a right shoulder decompression and modified Mumford procedure, with decompression of the acromioclavicular joint, coracoacromial ligament and a partial rotator cuff repair. The patient continued with complaints of right shoulder pain and stiffness and was referred for a work condition/hardening program. On 4/17/03 the patient underwent an FCE and began a work conditioning/hardening program on 4/18/03.

Requested Services

WH-AP-Work hardening/conditioning-initial, WH-AP-Work hardening/conditioning each additional hour, functional capacity eval, ov, conduc paste, neuromuscular stim, elec shock unit from 4/18/03 through 8/21/03.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Ergos evaluation summary report 4/17/03, 5/8/03, 6/4/03
2. Ortho office notes 5/20/02 –9/3/03
3. X-Ray report 5/10/03, 5/20/02
4. Work Hardening/Conditioning notes 4/18/03 – 8/21/03

Documents Submitted by Respondent:

1. Medical Review 12/27/03, 1/19/03, 1/24/03, 8/1/02
2. DDR 4/25/02, 6/18/02, 2/19/02
3. MRI report 1/29/02
4. X-Ray report 12/14/01, 5/10/03
5. Operative note 7/18/02
6. Ortho notes 5/20/02-7/22/02
7. Office notes 4/21/03 – 4/24/03
8. Ergos evaluation summary report 5/8/03
9. Work hardening/conditioning notes 5/9/03 – 8/21/03

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is partially overturned.

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a female who sustained a work related injury to her right shoulder on ____. The ___ physician reviewer indicated that the patient received traditional physical therapy with no improvement and underwent surgical decompression of the AC joint on 7/18/02 followed by physical therapy without significant improvement. The ___ physician reviewer noted that the patient was referred for a work hardening program and underwent an initial FCE on 4/17/03 that determined she was capable of light duty work. The ___ physician reviewer also noted that the patient underwent work hardening and behavioral therapy and that a repeat FCE on 5/8/03 indicated some improvement in endurance, however she remained at a light duty work capacity. The ___ physician reviewer indicated that the patient continued in the work hardening program and a reevaluation FCE on 6/4/03 showed that the patient had regressed to not being able to perform light duty work. The ___ physician reviewer explained that the patient's range of motion measurement from 5/5/03 through 6/12/03 showed some improvement, however the patient's pain level showed no significant improvement. The ___ physician reviewer also explained that the patient showed improvement up to 5/8/03, however the patient's condition had declined by 6/4/03. The ___ physician reviewer further explained that the work hardening program was not successful and not necessary after 6/4/03 because the patient was not benefiting from the program. Therefore, the ___ physician consultant concluded that the WH-AP-Work hardening/conditioning-initial, WH-AP-Work hardening/conditioning each additional hour, functional capacity eval, ov, conduc

paste, neuromuscular stim, elec shock unit from 4/18/03 through 6/4/03 were medically necessary. However, the ___ physician consultant concluded that the WH-AP-Work hardening/conditioning each additional hour, functional capacity eval, ov, conduc paste,

neuromuscular stim, elec shock unit from 6/5/03 through 8/21/03 were not medically necessary to treat this patient's condition.

Sincerely,