

MDR Tracking Number: M5-04-2125-01

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 3-12-04.

The Medical Review 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 conference by physician, office visits, electrical stimulation, call by physician to patient, massage therapy, prolonged evaluation, therapeutic exercises, and hot/cold packs therapy from 3/21/03 through 6/04/03 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 Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service 3/21/03 through 6/04/03 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 22nd day of June 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division

RLC/rlc

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

June 2, 2004

Re: IRO Case # M5-04-2125

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 Doctor of Chiropractic who is licensed by the State of Texas, 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:

Medical Information Reviewed

1. Table of disputed services 3/21/03 – 6/4/03
2. Explanation of benefits
3. Letter 4/21/04
4. Request for reconsideration 11/24/03
5. Review report 11/13/02
6. IR report 5/27/03
7. Evaluation reports left shoulder
8. TWCC change of treating doctors 3/12/03
9. Work hardening notes
10. Daily medication sheets
11. Productivity index sheets
12. Final FCE 4/11/03
13. Treatment notes for dates in dispute, and for dates prior to dispute
14. Motion x-ray report 5/15/03
15. MRI left shoulder report 7/19/02
16. NCS report 8/26/02

History

The patient injured his left shoulder in ___ when he lifted an object off a high shelf and felt sudden pain in his shoulder. He was evaluated by x-rays, MRI and electrodiagnostic studies, and has been treated with chiropractic treatment, medication and a work hardening program.

Requested Service(s)

Conf by phys, ov, elec stim, call by phys to patient, mas ther, prolonged eval, ther exer, hot-col pack ther 3/21/03-6/4/03

Decision

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

Rationale

The patient had extensive conservative treatment and work hardening/conditioning prior to the dates in dispute, with good results. Injuries such as the patient's respond very well to treatment without the need for a highly structured program. Flare-ups are common and respond well to myofascial release, transverse friction, cryotherapy, electrical muscle stimulation, OTC medication and instruction for home care.

Many unnecessary services were billed for this case of tendonitis, which should have responded well to home care and OTC medication. The patient's long-term, chronic, supervised care appears from the records provided to have encouraged doctor dependency.

The treatment notes provided are very limited and lack objective complaints and quantifiable findings that are necessary to show the medical necessity necessity of treatment

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