

MDR Tracking Number: M5-04-2139-01

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 3-15-04.

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 \$650** 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 therapeutic exercises, therapeutic procedures, massage, manual therapy, and occupation therapy re-evaluation from 8/20/03 through 9/26/03 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed service.

This Findings and Decision is hereby issued this 22nd day of June 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 8/20/03 through 9/26/03 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 Order is hereby issued this 22nd day of June 2004.

David R. Martinez, Manager
Medical Dispute Resolution
Medical Review Division
DRM/rlc

May 25, 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

This patient was injured on the job on ___ when she fell descending a ladder, landing on her right side and injuring her right arm, low back and head. She was treated with physical therapy and medication. A MRI of her right shoulder was positive for impingement at the anterior musculotendinous junction and arthritis of the AC joint. Right shoulder arthroscopic surgery was performed on 06/23/03. She had an initial post surgical physical performance evaluation on 07/09/03 and began post-surgical therapy. The insurance carrier has declined payment of therapy due to lack of significant objective benefit.

DISPUTED SERVICES

Under dispute is the medical necessity of therapeutic exercises, therapeutic procedures, massage, manual therapy, and occupational therapy reevaluation from 08/20/03 through 09/26/03.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

One would expect to see improvement of her shoulder post-surgically within eight to ten weeks. The dates in question certainly fall within this time frame, and the physical performance evaluations show improvement. The dates in question are deemed medically appropriate. The insurance company's stance is that no significant improvement was shown, but they did not review the entire therapy regimen. Instead, they reviewed just a couple of dates of service at a time. The efficacy of the treatment cannot accurately be judged in that manner.

___ 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,