

MDR Tracking Number: M5-04-3377-01

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 06-01-04.

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 manual therapy techniques, myofascial release, therapeutic exercises, hot or cold packs and physical therapy re-evaluation were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

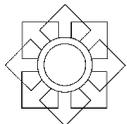
Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service from 07-09-03 to 12-03-03 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Findings and Decision is hereby issued this 3rd day of September 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

Enclosure: IRO decision



Texas Medical Foundation

Barton Oaks Plaza Two, Suite 200 • 901 Mopac Expressway South •
Austin, Texas 78746-5799
phone 512-329-6610 • fax 512-327-7159 • www.tmf.org

NOTICE OF INDEPENDENT REVIEW DECISION

August 18, 2004

AMENDED 08/2704

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker: _____
MDR Tracking #: M5-04-3377-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) 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 TMF for independent review in accordance with TWCC §133.308 which allows for medical dispute resolution by an IRO.

TMF 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 TMF physician reviewer who is board certified in orthopedic surgery which is the same specialty as the treating physician, provides health care to injured workers, and licensed by the Texas State Board of Medical Examiners in 1962. The TMF physician reviewer 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 TMF 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 30 year-old male is a professional hockey player who was injured when he fell on his right shoulder during a game on ____, resulting in a grade V acromioclavicular (AC) separation. He underwent an AC joint reconstruction on 01/15/03 with subsequent removal of a screw from the joint in March of 2003. In April of 2003 he began a physiotherapy program and has also had Cortisone injections in the AC joint.

Requested Service(s)

Myofascial release, manual therapy techniques, therapeutic exercise, hot or cold packs, and physical therapy re-evaluation for dates of service 07/09/03 through 12/03/03.

Decision

It is determined that the use of myofascial release, manual therapy techniques, therapeutic exercise, hot or cold packs, and physical therapy re-evaluation was not medically necessary for the treatment of this patient's medical condition from 07/09/03 through 12/03/03.

Rationale/Basis for Decision

This patient is post joint reconstruction and the remaining joint is now arthritic secondary to trauma and meniscus removal. Physical therapy and manual therapy will never help this problem. Therefore, the use of myofascial release, manual therapy techniques, therapeutic exercise, hot or cold packs, and physical therapy re-evaluation was not medically necessary for the treatment of this patient's medical condition from 07/09/03 through 12/03/03.

Sincerely,

A handwritten signature in black ink, appearing to read "Gordon B. Strom, Jr.", written in a cursive style.

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:vn

Attachment

Information Submitted to TMF for TWCC Review

Patient Name: ____

TWCC ID #: M5-04-3377-01

Information Submitted by Requestor:

- Physical Therapy orders
- Physical Therapy updates and progress reports 04/16/03-06/14/04
- Independent Medical Examination

Information Submitted by Respondent: