

MDR Tracking Number: M5-04-3723-01

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 (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 6-28-04.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

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, office visits, joint mobilization, and manual therapy techniques rendered from 7/07/03 through 7/16/03 **were found** to be medically necessary. therapeutic exercises, office visits, joint mobilization, and manual therapy techniques from 7/17/03 through 8/22/03 **were not** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

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 7/07/03 through 7/16/03 as outlined above 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 October 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division

RLC/rlc

September 2, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-3723-01
TWCC #:

Injured Employee:
Requestor:
Respondent:
----- Case #:

----- 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 chiropractor on the ----- external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ----- chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor 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 ----- chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 38 year-old male who sustained a work related injury on ----- . The patient reported that while at work he injured his right shoulder when he was running a jackhammer. The patient underwent an MRI of the right shoulder on 4/4/03 that was reported to have revealed a small focal full thickness supraspinatus tendon tear. On 4/23/03 the patient underwent right shoulder rotator cuff tendon repair. Further treatment for this patient's condition has included joint mobilization, ultrasound, electrical stimulation, hot/cold pack, and manipulation.

Requested Services

Therapeutic exercises, office visits, joint mobilization, manual therapy technique from 7/7/03 through 8/22/03.

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

Documents Submitted by Requestor:

1. Daily Treatment Log Notes 4/1/03 – 11/24/03
2. Treatment Notes 6/16/03

Documents Submitted by Respondent:

1. MRI report 4/4/03

2. X-ray report 3/22/03
3. Initial Evaluation 4/1/03
4. Operative note 4/23/03
5. Office notes/treatment logs 5/2/03 – 8/22/03

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 ----- chiropractor reviewer noted that this case concerns a 38 year-old male who sustained a work related injury to his right shoulder on ----- . The ----- chiropractor reviewer also noted that on 4/23/03 the patient underwent right shoulder tendon repair followed by postoperative physical therapy/rehabilitation from 5/5/03 through 6/16/03. The ----- chiropractor reviewer indicated that on 6/16/03 the patient was evaluated by his orthopedic surgeon and was found to still have deficits in range of motion, strength, and overhead reaching. The ----- chiropractor reviewer noted that the patient was recommended for 4 additional weeks of physical therapy/rehabilitation. The ----- chiropractor reviewer explained that this recommendation falls within the American Association of Orthopedic Surgery guidelines for shoulder surgery rehabilitation. The ----- chiropractor reviewer also explained that postoperative rehabilitation could extend between 8 to 10 weeks. The ----- chiropractor reviewer indicated that postoperative rehabilitation resumed on 6/18/03. Therefore, the ----- chiropractor consultant concluded that the therapeutic exercises, office visits, joint mobilization, manual therapy technique from 7/7/03 through 7/16/03 were medically necessary to treat this patient's condition. However, the ----- chiropractor consultant further concluded that the therapeutic exercises, office visits, joint mobilization, manual therapy technique from 7/17/03 through 8/22/03 were not medically necessary to treat this patient's condition.

Sincerely,