

MDR Tracking Number: M5-04-3889-01

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, 133.307 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. This dispute was received on 07-13-04.

The IRO reviewed therapeutic exercises, electric stimulation unattended, supplies and materials, neuromuscular reeducation, patient evaluation and therapeutic procedures group rendered from 10-16-03 through 12-02-03 that were denied based upon "U".

The IRO determined that therapeutic exercises, electric stimulation unattended, supplies and materials, neuromuscular re-education, patient re-evaluation and therapeutic procedures-group from 10-16-03 through 11-20-03 **were** medically necessary. The IRO determined that therapeutic exercises, electric stimulation unattended, supplies and materials, neuromuscular re-education, patient re-evaluation and therapeutic procedures-group from 11-24-03 through 12-02-03 **were not** medically necessary.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the **majority** of 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 \$650.00** 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 not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 08-09-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

CPT code 97001 date of service 10-14-03 denied as "K" (not applicable healthcare provider). The services rendered are within the scope and practice of the provider rendering the service. Reimbursement of \$85.45 per the Medical Fee Schedule effective 08-01-03 is recommended.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for 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 Decision is applicable for dates of service 10-14-03 through 11-20-03 in this dispute.

This Findings and Decision and Order are hereby issued this 7th day of October 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

September 16, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-3889-01
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 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 21 year-old male who sustained a work related injury on ----- . The patient reported that while at work he injured his right shoulder while swinging a sledge hammer. The diagnoses for this patient have included right rotator cuff tendinosis and AC joint sprain/grade II

injury. The patient had initially been treated with physical therapy and injections. The patient was referred to the treating facility and was evaluated on 10/14/03. The patient then began a course of physical therapy following the parameters of his treating physician's rotator cuff protocol.

Requested Services

Therapeutic exercises, electric stimulation unattended, supplies and materials, neuromuscular reeducation, patient reevaluation and therapeutic procedures-group from 10/16/03 through 12/2/03.

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

Documents Submitted by Requestor:

1. New Patient Evaluation 10/8/03
2. Physical Therapy initial Evaluation 10/14/03
3. Progress Notes 10/10/03 – 12/2/03
4. SOAP Notes 10/16/03 – 11/26/03
5. Rotator Cuff Exercise Protocol

Documents Submitted by Respondent:

1. No documents submitted

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 21 year-old male who sustained a work related injury to his right shoulder on ----- . The ----- physician reviewer indicated that the patient was evaluated on 10/8/03 and was found to have full range of motion in the neck and right shoulder, and positive rotator cuff tendonitis and AC sprain grade II. The ----- physician reviewer noted that an evaluation performed on 10/14/03 indicated mild or minimal decrease in range of motion of the right shoulder, right shoulder strength 3/5, and positive pain. The ----- physician reviewer indicated that by 11/20/03 the patient showed some gains in range of motion and motor strength increased and that the patient was progressing with weight bearing exercises. The ----- physician reviewer explained that considering the patient's job (working a sledge hammer-heavy physical work), a grade III motor strength in the right shoulder along with pain does not indicate that the patient would return to preinjury work status. The ----- physician reviewer indicated that the physical therapy treatment received between 10/16/03 through 11/20/03 were medically necessary. The ----- physician reviewer explained that there was no objective documentation provided that showed that the patient progressed after 11/20/03. Therefore, the ----- physician consultant concluded that the therapeutic exercises, electric stimulation unattended, supplies and materials, neuromuscular reeducation, patient reevaluation and therapeutic procedures-group from 10/16/03 through 11/20/03 were medically necessary to treat this patient's condition. The ----- physician consultant further concluded that the

therapeutic exercises, electric stimulation unattended, supplies and materials, neuromuscular reeducation, patient reevaluation and therapeutic procedures-group from 11/24/03 through 12/2/03 were not medically necessary to treat this patient's condition.

Sincerely,