

MDR Tracking Number: M5-04-3979-01

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 July 21, 2004.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the majority of the 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 the only issue** to be resolved. The therapeutic activities, hot/cold pack therapy, and office visit from 10/23/03 through 12/30/03 were found to be medically necessary. The therapeutic activities hot/cold pack therapy, and office visit from 1/12/04 through 2/13/04 were not found to be medically necessary. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

#### ORDER

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 for dates of service rendered 10/23/03 through 12/30/03 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 8<sup>th</sup> day of October 2004.

Margaret Q. Ojeda  
Medical Dispute Resolution Officer  
Medical Review Division

MQO/mqo

September 17, 2004

## NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M5-04-3979-01**  
**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 male who sustained a work related injury on ----- . The patient reported that while at work he injured his left shoulder. The patient reportedly sustained a left shoulder rotator tear and underwent repair on 6/6/02. Postoperatively the patient was treated with physical therapy and rehabilitation. The patient reported that he was reinjured during his postoperative physical therapy and rehabilitation and changed treating facilities. The patient presented to the current treating facility on 8/5/02 and continued a physical therapy rehabilitation program. The patient subsequently underwent a second rotator cuff repair to the left shoulder on 7/29/03. The patient was again treated with postoperative physical therapy and rehabilitation. The patient reported that he reinjured his left shoulder rotator cuff. The patient received three more treatments and was discharged from care.

### Requested Services

Therapeutic activities, hot/cold pack therapy, and office visit from 10/23/03 through 2/13/04.

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

*Documents Submitted by Requestor:*

1. Position Statement 8/11/04
2. Position Statement 8/16/04
3. SOAP Notes 10/23/03 – 2/13/04

*Documents Submitted by Respondent:*

1. No documents submitted

Decision

The Carrier's denial of authorization for the requested services is partially overturned.

Rationale/Basis for Decision

The ----- physician reviewer noted that this case concerns a male who sustained a work related injury to his left shoulder on -----. The ----- physician reviewer indicated that the patient underwent an initial rotator cuff repair on 6/6/02 and a second rotator cuff repair of the same shoulder on 7/29/03. The ----- physician reviewer noted that on 9/17/03 the patient began postoperative physical therapy. The ----- physician reviewer indicated that the patient made some progress and showed improvement with range of motion, increased shoulder strength, and pain had decreased as of 12/30/03. The ----- physician reviewer explained that at this point the patient had functional range of motion and 4 to 5/5 strength in the left shoulder. The ----- physician reviewer also explained that the patient had plateaued in physical therapy and could have been discharged to independent care or a home exercise program. Therefore, the ----- physician consultant concluded that the therapeutic activities, hot/cold pack therapy, office visit from 10/23/03 through 12/30/03 were medically necessary to treat this patient's condition. However, the ----- physician consultant further concluded that the therapeutic activities, hot/cold pack therapy, office visit from 1/12/04 through 2/13/04 were not medically necessary to treat this patient's condition.

Sincerely,