

MDR Tracking Number: M5-04-4056-01

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 26, 2004.

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 \$650.00** 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 exercises, manual therapy, electrical stimulation unattended, patient re-evaluation, and therapeutic activities were found to be medically necessary. The respondent raised no other reasons for denying reimbursement of therapeutic exercises, manual therapy, electrical stimulation unattended, patient re-evaluation, and therapeutic activities.

## 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 to dates of service 12/15/03 through 1/5/04 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

## NOTICE OF INDEPENDENT REVIEW DECISION

September 29, 2004

Rosalinda Lopez  
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 #: M5-04-4056-01  
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 1950. 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 55 year-old male injured his right shoulder on \_\_\_ when he slipped on some mud and grabbed behind him to prevent a fall. His arm was pulled in an overhead elevation and abduction. His diagnosis is right rotator cuff tear, right acromioclavicular joint arthritis and impingement syndrome. He has been treated with therapy, medications and surgery.

#### Requested Service(s)

Therapy exercise-97110, manual therapy techniques-97140, electrical stimulation-unattended-G0283, patient re-evaluation-97002, and therapy activities-97530 for dates of service 12/15/03 through 01/05/04.

#### Decision

It is determined that there is medical necessity for the therapy exercise, manual therapy techniques, electrical stimulation-unattended, patient re-evaluation, and therapy activities for dates of service 12/15/03 through 01/05/04.

#### Rationale/Basis for Decision

Medical record documentation indicates the necessity for the therapy exercise, manual therapy techniques, electrical stimulation-unattended, patient re-evaluation, and therapy activities. The patient had surgery on his right shoulder in September 2003 and developed acute shoulder pain in December 2003. Physical therapy for these acute symptoms was prescribed and was carried out for nine sessions during the dates of service 12/15/03 through 01/05/04. The amount of physical therapy was reasonable and appropriate and the patient progressively benefited from the physical therapy. Therefore, the services in question were medically necessary to treat this patient's medical condition.

Sincerely,