

MDR Tracking Number: M5-05-0761-01

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 10-29-04.

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 supervised physical therapy for manual therapy technique, neuromuscular re-education, therapeutic exercises, electrical stimulation 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 12-22-03 to 02-11-04 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Findings and Decision is hereby issued this 18th day of January 2005.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

NOTICE OF INDEPENDENT REVIEW DECISION – AMENDED DECISION

Date: January 10, 2005

To the Attention Of: Rosalinda Lopez
TWCC
7551 Metro Center Drive, Suite 100, MS-48
Austin, TX 78744-16091

RE: Injured Worker:
MDR Tracking #: M5-05-0761-01
IRO Certificate #: 5242

Forté 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 Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté has performed an independent review of the proposed 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 an orthopedic surgeon reviewer (who is board certified in orthopedic surgery) who has an ADL certification. The 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 for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- Table of disputed services dated 12/22/03 through 2/11/04
- Explanation of benefits for disputed services provided
- Progress notes from _____
- Functional capacity evaluation by _____

Submitted by Respondent:

- None provided

Clinical History

The claimant has a history of chronic right shoulder pain allegedly related to a compensable injury that occurred on or about _____. The claimant is status post rotator cuff repair on 10/16/03. The claimant completed a series of supervised physical therapy visits prior to dates of service in dispute.

Requested Service(s)

Supervised physical therapy for CPT Codes 97140, manual therapy technique; 97112, neuromuscular re-education; 97110, therapeutic exercises; G0283, electrical stim; and 97002, physical therapy re-evaluation from 12/22/03 to 2/11/04.

Decision

I agree with the insurance carrier that the requested intervention is not medically necessary.

Rationale/Basis for Decision

Generally supervised physical therapy is indicated for treatment of significant deficits in range of motion and functional capacity usually associated with acute injury and perioperative conditions. The claimant completed a series of supervised physical therapy visits following a rotator cuff repair surgery on 10/16/03. The documentation indicates the claimant had achieved a functional range of motion by 12/1/03 with a shoulder flexion of 110°, abduction of 90°, and functional internal rotation and external rotation. There is no clearly documented clinical rationale explaining why a well structured home exercise program would be any less effective than continued active intervention in this clinical setting.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 10 day of January 2005.

Signature of IRO Employee: