MDR Tracking Number: M5-03-0281-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 **or January 1, 2003** and Commission Rule 133.305 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 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 $460.00** 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 treatment/service rendered 9-20-01 to 1-23-02 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for these charges.

The above Findings and Decision are hereby issued this 27th day of May 2003.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

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 9-20-01 through 1-23-02 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 27th day of May 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution Officer
Medical Review Division

RL/dzt

NOTICE OF INDEPENDENT REVIEW DECISION

May 22, 2003

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
4000 South IH-35, MS 48
Austin, TX 78704-7491

MDR Tracking #: M5-03-0281-01
IRO Certificate #: IRO 4326

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

___ 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 cumentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___ health care professional 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.

Clinical History

This patient slipped on the ice and fell while on a work assignment on ___ hitting his right shoulder. He started physical therapy without improvement of his shoulder pain. An MRI performed in November of 2001 revealed supraspinatus tendinopathy and possible rotator cuff tear. The patient underwent right shoulder arthroscopic surgery on 11/09/01. The injury was found to be more extensive than previously diagnosed. After release from the orthopedic surgeon, he returned to his chiropractor for post-operative physical therapy and rehabilitation.

Requested Service(s)

Physical therapy treatments rendered from 09/20/01 through 01/23/02

Decision

It is determined that the physical therapy treatments rendered from 09/20/01 through 01/23/02 were medically necessary to treat this patient’s condition.

Rationale/Basis for Decision

First, the treatments provided prior to the surgery (i.e. nerve testing, x-rays, etc.) were medically necessary due to tingling and numbness in the right upper extremity. Secondly, the post-surgical rehabilitation, which lasted from 12/11/01 through 01/23/02, falls within the accepted guidelines for rotator cuff repair according to Maxey and Magnusson in "Rehabilitation for the Post-Surgical Orthopedic Patient". Therefore, the physical therapy treatments rendered from 09/20/01 through 01/23/02 were medically necessary.

Sincerely,