

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 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(q)(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 disputed office visits, therapeutic activities and electrical stimulation were found to be medically necessary. The respondent raised no other reasons for denying reimbursement.

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 3/29/02 through 9/25/02.

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 30th day of January 2003.

Noel L. Beavers
Medical Dispute Resolution Officer
Medical Review Division

NLB/nlb

January 21, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M5 03 0843 01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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 care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Doctor of Chiropractic. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

CLINICAL HISTORY

This patient suffered a serious traction type of injury to the left shoulder while working as a certified nurse midwife. She was opening a tray on a table that was stuck and suffered an immediate onset of pain in the left shoulder. She was initially treated by ___ and later changed to ___ in ___. Treatment is for the left shoulder pain which extends into the mid back and neck. A peer review was performed by ___, who denied all current and future care apparently because the patient had reached MMI. He also states that the patient's subjective complaints have improved, but that there is no objective evidence of that.

Office notes from ___ indicate that the patient has significant pain indicators on orthopedic testing and is documented to be getting steady relief of symptoms in the treatment program.

DISPUTED SERVICES

The carrier has declined office visits, therapeutic activities and electrical stimulation from March 29, 2002 through September 25, 2002.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The peer reviewer on this case has denied that the care on this case is related to the compensable injury. I happen to disagree. The documentation clearly demonstrates a reasonable pattern of progression in an injury that was probably more serious than previously expected by the treating doctors. The patient's ongoing care was within the requirements of the Texas Labor Code and would be considered reasonable based on the documentation, which demonstrated a clear relief from pain and an increase in functional ability due to the decrease in pain. In this case, I must give the patient the benefit of the doubt and I find that the care rendered was reasonable for this patient's condition.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,