MDR Tracking Number: M5-03-0884-01

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 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 $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 chronic pain management program, electrical heat pad and Bio-freeze gel were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for these chronic pain management program, electrical heat pad and Bio-freeze gel charges.

This Finding and Decision is hereby issued this 23rd day of May 2003.

Carol R. Lawrence
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 1/1 through 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 23rd day of May 2003.

David R. Martinez, Manager
Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

DRM/crl
RL/cl

May 21, 2003

Re: MDR #: M5-03-0884-01

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is Certified in Chiropractic medicine.

Clinical History:
This male claimant sustained a work-related injury to his right shoulder on ___. Following an MRI of the right shoulder, the patient underwent arthroscopic surgery on 12/15/00, followed by physical therapy and chiropractic care. MRI of the shoulder on 02/13/01 revealed a small amount of fluid in the subacromial bursa. He underwent right shoulder manipulation under anesthesia on 03/26/01.

The patient began a pain management program on 02/23/01. At that time, he was diagnosed with the expected physical problems associated with a right shoulder injury, and also depression, related to the ___ injury. He was given medication to help "sleep and mediate the symptoms of the depression". He was placed at MMI with a 5% WP on 05/10/01, and at MMI with a 11% WP impairment on 06/12/01.

On 09/21/01, the patient was referred back for "multidisciplinary chronic pain management" that began on 12/03/01 and ended on 01/24/02. He was returned to work on 02/05/02, after the pain management program was completed.

Disputed Services:
Chronic pain management program, electrical heat pad and Bio-Freeze gel during the period of 12/03/01 through 01/21/02.

Decision:
The reviewer disagrees with the determination of the insurance carrier. The reviewer is of the opinion that the treatment in question was medically necessary in this case.

Rationale for Decision:
The Upper Extremity Treatment Guidelines place this patient under the Tertiary Level of Care. Treatment interventions at this level would include "Biofeedback/behavioral pain management/relation training/mental health treatment".

According to the records provided, this patient was suffering from depression and associated sleep disturbances that were related to the shoulder injury. The purpose of the pain management program was to treat his "ongoing discomfort, sleep/mood disturbances and (his inability) to resume productive employment". The testing, GAF and PSS, place the patient at the "moderate" level as outlined in the Mental Health Treatment Guidelines.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,