

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 chiropractic treatments were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for these chiropractic treatment charges.

This Finding and Decision is hereby issued this 15<sup>th</sup> day of July 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 6/17/02 through 11/26/02 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 15<sup>th</sup> day of July 2003.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

RL/crl

**IRO Certificate #4599**

**NOTICE OF INDEPENDENT REVIEW DECISION**

July 3, 2003

**Re: IRO Case # M5-03-1753-01**

Texas Worker's Compensation Commission:

\_\_\_ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule 133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to \_\_\_ for an independent review. \_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, \_\_\_ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Physical Medicine and Rehabilitation. He or she has signed a certification statement attesting 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 referral to \_\_\_ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the \_\_\_ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient is a 45-year-old male who was injured on \_\_\_ when was stacking pipe while standing on an unstable surface. A pipe fell over and he injured his right shoulder while attempting to catch the falling pipe. He was initially treated by a chiropractor with active and passive physical therapy of the right shoulder. He was then referred for orthopedic surgical evaluation, and he subsequently underwent surgical repair of the rotator cuff and acromioplasty. Post-operatively he reportedly underwent six to eight weeks of physical therapy. The patient's pain continued and he was referred back to the orthopedic surgeon, who performed manipulation under anesthesia for adhesive capsulitis.

Requested Service(s)

Chiropractic treatments 6/17/02-11/26/02

Decision

I disagree with the carrier's decision to deny the requested treatment.

Rationale

The patient suffered a torn rotator cuff which required surgical repair. Post-operatively he developed adhesive capsulitis, which required manipulation under anesthesia. He then was treated with physical therapy over the subsequent five months. At the beginning of the physical therapy program the patient's range of motion was reported as being severely limited. Gradual improvement is documented throughout the program. The physical therapy does not appear to have been excessive. Physical therapy is appropriate following rotator cuff surgery and manipulation under anesthesia.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

Sincerely,