

MDR Tracking Number: M5-03-2010-01

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 \$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 FCE, office visits, therapeutic procedures and aquatic therapy were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for these FCE, office visits, therapeutic procedures and aquatic therapy charges.

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 10/3/02 through 10/10/02 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 9th day of July 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

June 25, 2003

IRO Certificate # 5259

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or

rendered services is determined by the application of medical screening criteria published by ____, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

____ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ____.

CLINICAL HISTORY

____ was apparently injured while performing his duties as an Assistant Fire Chief for the ____ on _____. The mechanism of injury appears to be that the patient had a slip and fall injury, extended his arms to catch himself and injured his left shoulder. The patient apparently presented to the ____ and was evaluated on 07/17/2002 by ____ the patient was accepted as a patient and placed in a conservative protocol of treatment. Medical documentation made available for this review includes the initial physical examination on 07/27/2002, as well as follow-up evaluations on 09/13/2002 and 10/15/2002. Also available for this evaluation was and MRI of the left shoulder on 07/29/2002, which revealed and impingement syndrome with early degenerative joint disease of the left supraspinatus tendon and the rotator cuff, as well as biceps tendonitis. Two Functional Capacity Evaluations were available, the first dated 08/01/2002, which revealed a physical demand capacity of medium and the second on 10/08/2002, which revealed a physical demand capacity of heavy. Daily notes for 10/03/2002, 10/09/2002 and 10/10/2002 documented four units or one hour of aquatic therapy on the three dates as well as three units or forty-five minutes on 10/03/2002 and 10/09/2002 and four units on 10/10/2002. A TWCC-73 form dated 10/15/2002 indicated that the patient had returned to work at full duty. There was a Peer Review dated 10/25/2002 from a _____. In his review ____ felt that no further chiropractic care was available and that future treatment options included possible injections, possible surgical intervention, if not surgical intervention, then recommendations were made for a Functional Capacity Evaluation and a possible work-conditioning program. Lastly, there is an office note dated 11/20/2002 from ____ stating the patient continued to have symptomatology and may require subacromial decompression if the symptoms continued to hurt in the next six weeks.

REQUESTED SERVICE (S)

The services in dispute include the Functional Capacity Evaluation performed on 10/08/2002 and the therapeutic procedures, aquatic therapy. And office visits on 10/03/2002, 10/09/2002, and 10/10/2002.

DECISION

Based on a review of the medical documentation listed above, it is the opinion of the reviewer that the Function Capacity Evaluation and the three dates of service were reasonable and necessary in the care of ____.

RATIONALE/BASIS FOR DECISION

It appears that the above four dates of service were denied per the Peer Review dated 10/25/2002. This peer Review was performed by ____, through which ____ indicated that he felt no further chiropractic care was necessary. ____ indicated in his report that he felt the patient should be reviewed for an orthopedic evaluation to determine if he was a surgical candidate; if he was not, he recommended a Function Capacity Evaluation, followed by a possible three to six week course of work conditioning. ____ did not feel that the patient would require chronic pain management program, work hardening, or individual psychotherapy. It is curious to note that this Peer Review was used in part to deny the Functional Capacity Evaluation. That being stated, ____ stated his opinion without listing what if any medical records were reviewed, nor did he cite the specific reasons why he felt no further care was necessary. Specifically, ____ did not rely upon the standard of medical necessity as defined by Texas law, which includes the relief of pain is sufficient to show medical necessity; he did not recite any rationale consistent with that standard, nor did he cite any medical authorities in support of his rationales. He simply indicated that the patient would require a Functional Capacity Evaluation and possible work conditioning. Based upon a review of the three physical examinations listed above as well as the Functional Capacities Evaluations listed above, it appears that the patient did make consistent progress with this treatment, he did undergo reasonable progressions and subjective and objective care and in fact did return to work without restriction prior to the Peer Review, without the need for work conditioning. Specifically, on the reevaluation program, apparently three times weekly, which appears to have been completed on 10/10/2002, and the patient apparently returned to work without restriction on 10/15/2002. All of the patient's physical examinations and Functional Capacity Evaluations did reveal an increase in not only range of motion, but also strength and functional capacity. I feel that the condition was adequately documented and diagnosed and the treatment program appears to have been appropriate not only to the standard of care that the State issued in the past, which was extensively stated by ____ in his request for the Independent Review Determination, but also all current rehabilitation standards.

In short, the patient did undergo a reasonable progression in his treatment plan, did respond favorably, and was able to return to work without an extensive work conditioning or work hardening program. The patient did have a follow-up evaluation with ____ on 11/20/2002, who felt the patient may require surgical intervention in the future but no further information is available at this time. Please make note that the above rationale is based solely upon the medical documentation that has been listed above. Based upon that documentation, the dates of service made available for this review do in fact appear to be reasonable and necessary, the services adhere to the criteria established in the Texas Labor 408.021a 1-3, the peer review used to deny care and did not meet the standards established for such reports in the State of Texas, and the provider should be compensated.