THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-04-3418.M5

MDR Tracking Number: M5-03-2163-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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. This dispute was received on 4-30-03.

The IRO reviewed office visits, electrical stimulation, therapeutic exercises, hot/cold packs, and ultrasound rendered from 10-2-02 through 12-19-02 that were denied as not medically necessary.

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 not the only issue** to be resolved.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On September 16, 2003, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
12/24/02	99213 97010 97014 97110 97124	48.00 11.00 15.00 105.00 28.00	0.00	No EOB	48.00 11.00 15.00 35.00 ea 15 min 28.00 ea 15 min	96 MFG Med GR I A 10 A; E/M GR VI B; CPT descriptors	Requestor did not submit documentation to support services rendered. No reimbursement recommended.
12/27/02	97010 97014 97110 97124	11.00 15.00 105.00 28.00	0.00	No EOB	11.00 15.00 35.00 ea 15 min 28.00 ea 15 min	96 MFG Med GR I A 10 A; CPT descriptors	Requestor did not submit documentation to support services rendered. No reimbursement recommended.
TOTAL		366.00	0.00				The requestor is not entitled to reimbursement.

The above Findings and Decision are hereby issued this 7th day of January 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for 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 Decision is applicable for dates of service 3-22-02 through 7-12-02 in this dispute.

This Order is hereby issued this 7th day of January 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dzt

December 24, 2003

NOTICE OF INDEPENDENT REVIEW DECISION
Corrected Letter

RE: MDR Tracking #: M5-03-2163-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 55 year-old male who sustained a work related injury on ___. The patient reported that while at work he tripped and fell injuring his right shoulder and back. The patient underwent X-Rays and began physical therapy. The patient then underwent an MRI that showed a torn rotator cuff and multiple disc herniations. The patient underwent rotator cuff repair on 4/15/02 that was followed by 14 weeks of physical therapy. The patient also underwent an EMG/NCV testing on 9/10/02. On 10/2/02 the patient was found to had developed capsulitis. He was then referred for more physical therapy for further low back management, increase range of motion.

Requested Services

Hot or cold packs, Ultrasound, electrical stimulation, massage therapy, therapeutic exercises, office visits from 10/2/02 through 12/19/02.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a 55 year-old male who sustained a work related injury to his right shoulder and back on ___. The ___ chiropractor reviewer also noted that the patient underwent a right shoulder MRI that showed a torn rotator cuff and multiple disc herniations. The ___ chiropractor reviewer further noted that the patient underwent a rotator cuff repair on 4/15/02 that was followed by 14 weeks of physical therapy. The ___ chiropractor reviewer indicated that the patient began therapy at Therapy Works with signs of adhesive capsulitis as well as lumbar spinal involvement. The ___ physician reviewer explained that the patient was treated conservatively with a steady progression of the shoulder and not much change in the lumbar spine. The ___ chiropractor reviewer noted that the lumbar spinal care was discontinued in December, but his shoulder care was continued. The ___ chiropractor reviewer explained that the patient showed steady progress despite findings of more restriction during an evaluation on 10/2/02. The ___ chiropractor reviewer indicated that the patient had more complete range of motion at the end of his care. The ___ chiropractor reviewer explained that shoulder problems take a considerable amount of time to recover from. The ___ chiropractor reviewer also explained that when lumbar disc involvement is also present with a shoulder injury, even more recovery time is usually required. Therefore, the ___ chiropractor consultant concluded that the hot or cold packs ultrasound, electrical stimulation, massage therapy, therapeutic exercises and office visits from 10/2/02 through 12/19/02 were medically necessary to treat this patient's condition.

Sincerely,

___