THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:
SOAH DOCKET NO. 453-04-3736.M5

MDR Tracking No. M5-03-2983-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 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 July 17, 2003.

The IRO reviewed work hardening program and office visit rendered from 1/21/03 through 3/11/03 that was denied based upon "U".

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$	Reference	Rationale
2/11/03	97545-WH	$128.00	$0.00	No EOB	$102.40	MFG, Medicine Ground Rule (II)(E)(1-10)	Review of the office note dated 2/11/03 supports delivery of service. The requestor is therefore entitled to reimbursement in the amount of $102.40.
	97546-WH	$384.00	$0.00	No EOB	$307.20	MFG, Medicine Ground Rule (II)(E)(1-10)	Review of the office note dated 2/11/03 supports delivery of service. The requestor is therefore entitled to reimbursement in the amount of $307.20.

TOTAL		$512.00	$0.00		$409.60		The requestor is entitled to reimbursement in the amount of $409.60.

This Decision is hereby issued this 30th day of January 2004.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

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 1/21/03 through 3/11/03 in this dispute.

This Order is hereby issued this 30th day of January 2004.

David R. Martinez, Manager
Medical Dispute Resolution
Medical Review Division

DRM/mqo

Enclosure: IRO Decision

September 5, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-2983-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
------ Case #:

------ 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. This ------ reviewer has been certified for at least level I of the TWCC ADL requirements 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 male who sustained a work related injury on ------. The patient reported that while at work he tripped and fell landing on his right shoulder. The patient has undergone an X-Ray of the right shoulder and was diagnosed with disorder of bursae and tendon in the shoulder region, paresthesia and deep and superficial muscle spasm. Initial treatment included an injection into the shoulder and physical therapy. The patient underwent an EMG/NCV on 8/21/02. The patient also underwent an MRI of the right shoulder that showed joint effusion, impingement of supraspinatus muscle, subclaivular and subsupraspinatus fluid and edema and probable rotator cuff injury/possible tear and or inflammation. The patient then underwent an open acromioplasty with division of CA ligament and bursectomy. The patient was then treated with post-surgical rehabilitation on 12/4/02 and a work hardening program from 1/14/03 through 3/11/03.

Requested Services

Work hardening from 1/21/03 through 3/11/03.

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 male who sustained a work related injury to his right shoulder on ------. The ------ chiropractor reviewer indicated that an MRI of the right shoulder that shoed joint infusion, impingement of supraspinatus muscle, subclaivular and subsupraspinatus fluid and edema and probable rotator cuff injury. The ------ chiropractor reviewer also indicated that the patient underwent a right shoulder X-Ray and was diagnosed with disorder of bursae and tendon in the shoulder region, paresthesia and deep and superficial muscle spasm. The ------ chiropractor reviewer noted that the patient underwent an open acromioplasty with division of CA ligament and bursectomy. The ------ chiropractor reviewer explained that the treatment from 1/21/03 through 3/11/03 was medically necessary and appropriate. The ------ chiropractor reviewer also explained that the patient responded well to the work hardening program from 1/21/03 through 3/11/03. Therefore, the ------ chiropractor consultant concluded that the work hardening from 1/21/03 through 3/11/03 was medically necessary to treat this patient's condition.

Sincerely,

State Appeals Department