MDR Tracking Number: M5-03-3144-01

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 8-1-03.

The IRO reviewed therapeutic exercises, joint mobilization, hot/cold packs, electrical stimulation, and therapeutic activities rendered from 12-18-02 through 12-31-02 and 1-3-03 through 2-17-03 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 $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.

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

On 9-22-03, 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 |
|---|---|---|---|---|---|---|---|
| 1-2-03 | 99213 | $80.00 | $0.00 | No EOB | $48.00 | 96 MFG E/M GR IV C 2 | Daily note supports delivery of service. Recommend reimbursement of $48.00. |
| TOTAL | | $80.00 | $0.00 | | | | The requestor is entitled to reimbursement of $48.00. |

The above Decision is hereby issued this 30th 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 12-18-02 through 2-17-03 in this dispute.

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

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division
RL/dzt

**IRO Certificate #4599**

**NOTICE OF INDEPENDENT REVIEW DECISION**

September 17, 2003

**Re: IRO Case # M5-03-3144**

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, Rule133.308 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 Orthopedic Surgery, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. 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 47-year-old female who injured her left shoulder on ___. Clinical examination was consistent with rotator cuff tear. An MRI/arthrogram revealed a full-thickness, non-retracted tear of the supraspinatus tendon. Surgery was performed on 11/19/02, and the patient received therapy for approximately three months post operatively.

Requested Service(s)
Therapeutic exercises, joint mobilization, hot or cod packs, electrical stimulation, therapeutic activities, training for daily living

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

Rationale
After arthroscopic evaluation of the shoulder, an open rotator cuff repair was performed. A minimum of eight weeks, and often 12-16 weeks of post-operative physical therapy is required to rehabilitate patient's after a rotator cuff repair. All of the requested services were medically reasonable and necessary.

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

Sincerely,