MDR Tracking Number: M5-03-3181-01

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 8-5-03.

The IRO reviewed work hardening, therapeutic procedures, office visits, massage, electrical stimulation, and hot/cold packs from 8-1-02 through 5-30-03 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**
6-3-03 6-4-03 6-5-03	99211 97110 x 4	$30.00 x3 $160.00 x3	$0.00	No EOB	$32.00 $35.00 ea 15 min	96 MFG Med GR I A 10 A; E/M GR VI B; Rule 133.307(g)(3)	Neither party submitted EOBs; therefore, this review will be per the MFG. Relevant information was not submitted to support delivery of services. No reimbursement can be recommended.
TOTAL		$570.00	0.00				The requestor is not entitled to reimbursement.

The above Findings and Decision are hereby issued this 3rd day of February 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 Order is applicable for dates of service 8-1-02 through 5-30-03 in this dispute.

This Order is hereby issued this 3rd day of February 2004.

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

September 19, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #:	M5-03-3181-01
IRO #:	5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor board certified and specialized in Occupational Medicine. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ was involved in a motor vehicle accident with injuries to his right knee, left shoulder, cervical spine and lumbar spine. He underwent a right knee arthroscopy on 11/7/01 with partial lateral meniscectomy and excision of plica, followed by post-operative therapy with resolution. He underwent a cervical operation on 2/25/02 with C4/5 and C5/6 discectomy and fusion, followed by post-operative therapy and six weeks of work hardening from 7/5/02 – 8/23/02. An FCE on 8/21/02 demonstrated improvement in his capabilities. Notes from a follow-up with his treating physician on 8/23/02 stated "we are done with the neck."

Attention was turned to the injured shoulder. An office evaluation by the treating physician on 10/25/02 scheduled the patient for shoulder surgery, and on 12/18/02 left shoulder acromioplasty, partial claviclectomy and bursectomy were performed. Office visits with his treating physician demonstrated improvement to the shoulder, but with continued limited range of motion. Physical therapy notes outlined the modalities that were provided. There was an office visit with the treating physician on 8/15/03 with continuation of conservative treatment.

DISPUTED SERVICES

Under dispute is the medical necessity of work hardening, therapeutic procedures, office visits, massage, electrical stimulation and hot and cold packs form 8/1/02 through 5/30/03.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The services rendered during this period of time appear to flow from and be related to the previous and ensuing treatment. Part of the treatment rendered during this time is a continuation of appropriate post-operative cervical spine rehabilitation. After the resolution of this problem, a different problem, the left shoulder, was treated. The operative intervention is necessary, as the patient failed conservative therapy and continued with pain and limited ROM with an MRI that showed impingement. The post-operative evaluations by the treating physician are necessary to monitor the patient's status. Physical therapy directed toward the shoulder during this time is also reasonable and necessary.

In summary, the ___ reviewer finds that all services from 8/1/02 through 5/30/03 were medically necessary for this patient's injuries.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,