

MDR Tracking Number: M5-03-3365-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on August 25, 2003.

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.

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 office visits, therapeutic exercises, joint mobilization, electrical stimulation, hot/cold packs and special supplies were found to be medically necessary. The respondent raised no other reasons for denying reimbursement of the office visits, therapeutic exercises, joint mobilization, electrical stimulation, hot/cold packs and special supplies 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 11/25/02 through 1/9/03 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 2<sup>nd</sup> day of December 2003.

Margaret Q. Ojeda  
Medical Dispute Resolution Officer  
Medical Review Division  
MQO/mqo

November 26, 2003

## NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M5-03-3365-01**

\_\_\_ 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 physician 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. This physician is board certified in physical medicine and rehabilitation. The \_\_\_ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician 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 \_\_\_ physician reviewer certified that the review was performed without bias for or against any party in this case.

### Clinical History

This case concerns a 52 year-old male who sustained a work related injury on \_\_\_. The patient reported that while at work he injured his neck, back and left shoulder. The diagnoses for this patient include cervical syndrome, myofascial pain, and a disc protrusion at the L4-L5 level. The patient underwent acromioplasty of the left shoulder. Postoperatively the patient was treated with therapy. Following the postoperative therapy, the patient was treated with further therapy for complaints of neck and back pain beginning 11/25/02. This therapy included therapeutic exercises, joint mobilization, electrical stimulation and hot/cold packs.

### Requested Services

Office visits, therapeutic exercises, joint mobilization, electrical stimulation, hot/cold packs and special supplies from 11/25/02 through 1/9/03.

### 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 \_\_\_ physician reviewer noted that this case concerns a 52 year-old male who sustained a work related injury to his left shoulder, neck and back on \_\_\_. The \_\_\_ physician reviewer indicated that the patient's left shoulder pain was treated with surgery and then rehabilitation.

The \_\_\_ physician reviewer noted that the physical therapy postoperatively was mainly for treatment of left shoulder range of motion, mobilization and strengthening. The \_\_\_ physician reviewer indicated that the patient continued to complain of neck and back pain.

However, the \_\_\_ physician reviewer explained that the patient had not received much therapy for these two conditions as therapy was focused on left shoulder rehabilitation postoperatively. The \_\_\_ physician reviewer explained that a progress note documents that the patient's upper back pain was possibly aggravated during shoulder rehabilitation.

The \_\_\_ physician reviewer further explained that although it was \_\_\_ months after the injury date that the patient began physical therapy for neck and back pain, it is possible that his original neck/upper back pain was aggravated during shoulder rehabilitation. Therefore, the \_\_\_ physician consultant concluded that the office visits, therapeutic exercises, joint mobilization, electrical stimulation, hot/cold packs and special supplies from 11/25/02 through 1/9/03 were medically necessary to treat this patient's condition.

Sincerely,