

MDR Tracking Number: M5-02-3016-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 **or January 1, 2003** and Commission Rule 133.305 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.

The amount of the disputed services found not medically necessary exceed that of those services found medically necessary. Therefore, the Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Therefore, in accordance with §133.308(q)(9), the Commission **Declines to Order** the respondent to refund the requestor for the paid IRO fee. In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

The IRO determined that the office visits of 4/18/01, 6/21/01, 7/26/01, 8/30/01 and 10/4/01 are medically necessary. The IRO determined the office visits of 7/30/01, 8/16/01, 8/17/01, 9/17/01 and 10/5/01 were not medically necessary. The IRO determined that 15 sessions of physical therapy from 6/5/01 to 7/26/01 consisting of hot/cold packs and one unit of therapeutic exercise each session along with 6 units of neuromuscular stimulation were medically necessary. The IRO determined that all physical therapy after 7/26/01, along with other modalities not previously listed by the IRO as medically necessary from 6/5/01 to 7/26/01, were not medically necessary. 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 respondent raised no other reasons for denying reimbursement.

This Order is hereby issued this 30th day of January 2003.

Noel L. Beavers
Medical Dispute Resolution Officer
Medical Review Division

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 4/18/01 through 7/26/01 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 30th day of January 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

Date: January 7, 2003 - correction

Requester/ Respondent Address : Rosalinda Lopez
TWCC
4000 South IH-35, MS-48
Austin, Texas 78704-7491

RE: MDR Tracking #: M5-02-3016-01
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced 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 proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by an Orthopedic Surgeon physician reviewer who is board certified in Orthopedic Surgery. The Orthopedic Surgeon physician reviewer has signed a certification statement stating 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 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 this case.

Clinical History

This review is in regards to disputed payment relative to the claimant, a 41 year old male who sustained an injury to the left shoulder on ___. Apparently as he was reaching for a battery on a shelf, he had to quickly restrain the battery from falling with resultant stress to the shoulder. The initial management was conservative and effective though the pain

later returned. Subsequent to that surgery, he underwent at least some 36 sessions of physical therapy with a variety of modalities, typically 3-4 and sometimes 6. With continued pain arising at the AC joint, he underwent further open decompression and resection of the distal clavicle/AC joint on 12/18/01, by a different orthopedic surgeon. The period in question is from 4/18/01, through 10/9/01. My board certification is in Orthopedic Surgery and the services provided are within the scope of my practice or supervision.

While not entirely successful, the first surgery of 5/11/01 seems appropriate and medically necessary in regard to the persistent left shoulder pain not responsive to time and conservative measures, as well as consistent to the pre-operative evaluation and studies.

Requested Service(s)

Physical therapy from 4/18/01 through 10/9/01, related office visits

Decision

While the records supplied to me are more than 2 inches thick and the details are multiple, I am in agreement with the insurance company that most of the services provided in the above time span were excessive or medically unnecessary.

Authorized: Office visits, dated 4/18/01, 6/21/01, 7/26/01, 8/30/01, 10/4/01, HOWEVER, the office visit E&M depth is not compatible with CPT 99213, and CPT 99212 should have been charged for these office visits.

Not authorized: Office visits dated 7/30/01, 8/16/01, 8/17/01, 9/17/01, 10/5/01

Authorized: physical therapy for 15 sessions, from 6/5/01 to 7/26/01, consisting of hot/cold packs and one unit of therapeutic exercise each. Additional, 6 units of neuromuscular stimulation, 97032, are considered as reasonable and necessary.

Not authorized: All physical therapy sessions subsequent to 7/26/01 and, during physical therapy sessions from 6/5/01 to 7/26/01, modalities in excess of those authorized above.

Rationale/Basis for Decision

The treatment in question consists of one session, dated 4/18/01, and then sessions running from 6/5/01 to 10/9/01. The date of injury is _____. The claimant received some initial physical therapy and subacromial injections, was pain free and had full range of motion by 2/15/01, and was declared at maximum medical improvement. He had a flare-up a month later. The office visit, dated 4/18/01, was a month after the flare-up, showed continued shoulder pain, and the claimant was referred for arthroscopic surgery. The office visit, dated 4/18/01, is considered to be medically necessary.

The claimant underwent arthroscopic surgery on 5/11/01. It would appear that the initial post-operative physical therapy evaluation, by the "Center for Occupational Medicine," took place on 6/5/01, although the post-op chart note states that physical therapy was to begin after the office visit of 5/23/01.

In connection with the extensive physical therapy, there is as well dispute about office visits. In that this patient was being attended to by his orthopedic surgeon in the postoperative period, there appears little if any justification for postoperative visits by other physicians in that typical 90-day global postoperative period. If there is continuing need for work comp documentation by a separate independent physician, one limited (CPT 99212) office visit per month over six months seems adequate. If there are continuing problems, this typically and appropriately falls to the operating surgeon.

Office visits were charged on 6/21/01, 7/26/01, 7/30/01, 8/16/01, 8/17/01, 8/30/01, 9/17/01, 10/4/01, 10/5/01. Monthly office visits would appear to be reasonable and necessary. On 7/30/01, an office visit was charged, just four days after the previous one. The form filled out could have been done so, based on the information from the previous office visit, therefore, the office visit dated 7/30/01, is not considered reasonable and necessary. Neither are the office visits, dated 8/16/01 and 8/17/01, 9/17/01 and 10/5/01, as they are more frequent than monthly, without a specific indication. Finally, the office visits are coded 99213. Follow-up office visits, in this respect, consist of a problem focused history and examination, and straightforward medical decision making, and should have been charged as 99212.

This case represents a situation in which the physician did not apparently exercise satisfactory supervision relative to the appropriateness of physical therapy in terms of duration, frequency, multitude of modalities, as well as effectiveness. The typical and appropriate post operative physical therapy for subacromial decompression/acromioplasty would be of 2-3 times weekly for six weeks, if not less – particularly in a case like this where the patient has had physical therapy even prior to the surgery. Therapy beyond this level would be unusual and probably limited to some supervision of a home exercise program, the patient perhaps seen once a week for 3-4 weeks at most. Post-operative therapy was initiated on 6/5/01. July 17, 2001 is the 6 week mark. On 7/26/01, the closest date where range of motion measurements are included, the claimant has been seen 14 times over an 8 week period of time. (There was a period of time from 6/18/01 to 7/2/01 when the claimant did not attend therapy sessions.) On 7/26/01, shoulder flexion is 140°, extension 40°, abduction 136°, external rotation 81°, and internal rotation 50°. Flexion and abduction strength is listed as 4+/5. In review of the opinion that no further formal physical therapy was indicated or medically necessary after 7/26/01.

While there are multiple charges for electrical stimulation/electrical current, ultrasound, diathermy, therapeutic exercises of variable units, and joint mobilization, there is little justification in the notes of the patient's condition to justify so many modalities for such an extended period of time. The charges for therapeutic exercises range from one to four

units, without the documentation needed to assess the appropriateness of the charges. There are additional charges for electrodes apparently for phonophoresis which again are unnecessary, particularly in regard to timing, and certainly not well supported by the physician or physical therapy notes. To be generous, physical therapy of hot/cold packs and one unit of therapeutic exercises would be appropriate postoperatively three times weekly for four weeks, followed by two sessions weekly for two additional weeks, then perhaps one similar visit weekly for two weeks – all formal physical therapy terminated at the two month level with expectation of continued home exercises. There either some element of pain control or neuromuscular reeducation. While there is some usefulness to this modality to augment the patient's own voluntary muscle action, there is little indication in this neurologically competent individual to continue this approach beyond three times weekly for two weeks. While the physical therapist might argue with me, the other modalities of diathermy/ultrasound/ phonophoresis function similarly to provide for heat application/thermopenetration. Consistent with this patient's picture, these more expensive heat modalities did not appear to provide any more sustained or useful benefit. In summary, it is my opinion that a total of 15 physical therapy sessions (through 7/26/01) postoperatively would have been the upper limit and that modalities be confined appropriately to hot/cold packs and one unit of therapeutic exercises, with 6 sessions to include the neuromuscular electrical stimulation.

In summary a thorough review of the records supplied to me regarding services rendered from 4/18/01 – 10/9/01, and in the context of my own medical practice which does include some work compensation care, it is my opinion that many of the physical therapy modalities as well as the frequency duration were excessive and in many cases medically unnecessary. Additionally, the documentation does not support payment for some of the physician visits on many occasions in that there appears some relative duplication of services not generally called for in orthopedic practice.

This decision by the IRO is deemed to be a TWCC decision and order.