

MDR Tracking Number: M5-02-3069-01

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 Medical Review Division has reviewed the IRO decision. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(q)(2)(C), the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

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. There are unresolved fee issues.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
07/16/01 07/17/01 07/18/01 07/19/01 09/04/01 09/05/01 09/06/01 09/07/01	97545-WH    97546-WH   99078-22  99071  99205	\$1,040.00 (\$65.00 X 16 hours)  \$3,120.00 (\$65.00 X 48 hours)  \$40.00  \$10.00  \$137.00	\$0.00	U	\$51.20 per hour (non CARF accredited)  \$51.20 per hour (non CARF accredited)  DOP  DOP  \$137.00	IRO Decision	The IRO determined the office visit, work hardening, educational services and supplies were not medically necessary. Therefore, no reimbursement is recommended.
07/20/01 09/10/01	97545-WH	\$390.00 (\$65.00 x 4 hours)	\$0.00	N	\$51.20 per hour (non CARF accredited)	MFG Medicine GR II. E.	“N – submitted documentation indicates that services rendered were primarily single disciplinary. Emphasizing conditioning

							tasks normally associated with work conditioning (97546WC)”  Daily notes (7/20/01 & 9/10/01) and Weekly progress reports (7/20/01 & 09/14/01) support service billed as a interdisciplinary program. Reimbursement recommended in the amount of \$204.80 (\$102.40 x 4 hours)
09/11/01 09/12/01 09/13/01	97545-WH	\$130.00 (\$65.00 x 6 hours)	\$307.0 0	F, A	\$51.20 per hour (non CARF accredited)	EOB dated 11/05/01  Rule 134.600	Preauthorization is required for work hardening after the completion of six weeks. The daily documentation shows that the injured worker did not complete a total of six weeks prior to returning to work. Therefore, preauthorization was not required.  Services paid at MAR, no further reimbursement recommended.
07/20/01 09/10/01	97546- WH	\$390.00 (\$65.00 x 6 hours)	\$0.00	N	\$51.20 per hour (non CARF accredited)	MFG Medicine GR II. E.	“N – submitted documentation indicates that services rendered were primarily single disciplinary. Emphasizing conditioning tasks normally associated with work conditioning (97546WC)”  Daily notes (7/20/01 & 9/10/01) and Weekly progress reports (7/20/01 & 09/14/01) support service billed as a interdisciplinary program. Reimbursement recommended in the amount of \$307.20.
09/11/01 09/12/01	97546- WH	\$1,170.00 (\$65.00 pr	\$921.6 0	F, A	\$51.20 per hour (non CARF	MFG Medicine	Preauthorization is required for work hardening after the

09/13/01		hr x 18 hrs)			accredited)	GR I. A. 8.  EOB dated 11/05/01  Rule 134.600 h.	completion of six weeks. The daily documentation shows that the injured worker did not complete a total of six weeks prior to returning to work. Therefore, preauthorization was not required.  Services paid at MAR, no further reimbursement recommended.
07/20/01	99361	\$55.00	\$0.00	N	\$53.00	MFG GR E/M XVIII. B.	“N – submitted documentation indicates that services rendered were primarily single disciplinary. Emphasizing conditioning tasks normally associated with work conditioning (97546WC)”  Documentation was not submitted referencing a team conference on this date. Therefore, no reimbursement recommended.
09/07/01	99361	\$55.00	\$0.00	F	\$53.00	MFG GR E/M XVIII. B.	“F- Only the coordinating doctor may bill for team conference per the evaluation and management section of the Texas medical fee guideline.”  Documentation was not submitted referencing a team conference on this date. Therefore, no reimbursement recommended.
09/14/01	99361	\$55.00	\$0.00	F, A	\$53.00	MFG GR E/M XVIII. B.  Rule 134.600	“F- Only the coordinating doctor may bill for team conference per the evaluation and management section of the Texas medical fee guideline.” “A- preauthorization not

							obtained”  Physician/ team conference is not a service that requires preauthorization.  Documentation was not submitted referencing a team conference on this date. Therefore, no reimbursement recommended.
09/13/01	99215	\$103.00	\$0.00	T	103.00	MFG Medicine GR I. 8.	“T- Physical and occupational therapist re-evaluation is limited to code 99213 per the medicine section. Page 31 of the 04/01/96 Texas Fee Guideline”  The Discharge Summary, dated 09/13/01, is signed by _____. Since the evaluation was performed by an occupational therapist, it is not eligible for reimbursement at this level. No reimbursement recommended.
TOTAL		\$6,435.00	\$1,488.60				The requestor is entitled to reimbursement of \$512.00.

On this basis, the total amount recommended for reimbursement (\$512.00) does not represent a majority of the medical fees of the disputed healthcare and therefore, the requestor did not prevail in the IRO decision. Consequently, the requestor is not owed a refund of the paid IRO fee.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay \$512.00 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 07/16/01 through 09/14/01 in this dispute.

This Order is hereby issued this 16th day of April 2003.

Laura L. Campbell  
Medical Dispute Resolution Officer  
Medical Review Division  
LLC/llc

**IRO Certificate #4599**

**NOTICE OF INDEPENDENT REVIEW DECISION**

January 10, 2003

**Re: IRO Case # M5-02-3069**

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 Physical Medicine and Rehabilitation. 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 was a then 30-year-old male fleet service worker for an airline who injured his right shoulder while lifting a bag on \_\_\_. He was initially treated with chiropractic treatment and physical therapy. An MRI of the right shoulder 2/21/01

was reportedly significant for a small partial thickness tear of the supraspinatus tendon. The patient underwent surgery 5/2/01 to repair the rotator cuff tear. Electrodiagnostic testing was performed 22/22/01. Nerve conduction studies were found to be abnormal. There was slowing of the motor nerve conduction velocity of the left ulnar nerve across the elbow and slowing of the distal sensory latencies of the median nerves bilaterally. Somatosensory-evoked potentials and neuromuscular junction testing was normal. The patient continued in physical therapy for range of motion and strengthening of his shoulder post operatively. According to a chiropractic peer review, the patient did not progress as well in rehab as expected. Strength and range of motion testing was conducted 6/27/01 showing that the range of motion on the right was decreased compared to the left only in adduction. All other planes, including abduction, were symmetrical or with the right greater than the left side. Muscle testing examination did demonstrate some weakness in the right shoulder compared to the left. The patient eventually entered a work hardening program 7/16/01, which lasted until 9/14/01. According to the progress notes, the work hardening program consisted of range of motion strengthening and endurance exercises, including job-simulated tasks. The patient also underwent therapy with a clinical psychologist. Following the work hardening program the patient was able to return to work.

#### Requested Service

Work hardening program 7/16/01 – 9/14/01

#### Decision

I agree with the carrier's decision to deny the disputed treatment.

#### Rationale

No documentation of a need for psychological counseling was included in the documentation provided for review. There is evidence of strength deficits in the right shoulder compared to the left. The patient would have benefited from continued physical therapy, and perhaps even from a single disciplinary work conditioning program consisting of job simulated tasks. There is no evidence of a need for a multi disciplinary program. The disputed program was clearly multi disciplinary with a psychological component.

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

## **YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing. A request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3). This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P O Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

Sincerely,