

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 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.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
9-24-01 9-26-01 9-28-01 10-1-01 10-5-01	97110	\$280.00 \$245.00 \$245.00 \$280.00 \$280.00	\$140.00 \$140.00 \$140.00 \$175.00 \$175.00	V, N	\$35.00 /15 min		The IRO concluded that these services were medically necessary; therefore, reimbursement of \$560.00 is recommended.
2-15-02	97110	\$280.00	\$140.00		\$35.00 /15 min		The IRO concluded that only two units were reasonable; therefore, additional reimbursement is not warranted.
TOTAL		\$1610.00	\$1010.00				The requestor is entitled to reimbursement of <b>\$560.00</b> .

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 May 15, 2003, 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	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
9-10-01 9-12-01 9-14-01	97110	\$280.00 \$280.00 \$280.00	\$175.00 \$210.00 \$245.00	F	\$35.00 /15 min	Medicine GR (I)(A)(9)(b)	The requestor did not submit documentation to support billed service; therefore, no reimbursement is recommended.
TOTAL		\$840.00	\$530.00				The requestor is not entitled to reimbursement.

Consequently, the commission has determined that **the requestor prevailed** on the majority of the medical fees. Therefore, upon receipt of this Order and in accordance with §133.308(q)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for 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 \$560.00 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 09/10/01 through 02/15/02 in this dispute.

This Order is hereby issued this 21<sup>st</sup> day of May 2003.

Elizabeth Pickle  
Medical Dispute Resolution Officer  
Medical Review Division

**NOTICE OF INDEPENDENT REVIEW DECISION - REVISION**

**Date:** June 10, 2003

**RE: MDR Tracking #:** M5-02-3211-01  
**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 a chiropractor reviewer. The chiropractor 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 claimant is a forty-eight (48) year old, 5'3", 179 lb. female who apparently suffered a fall while employed by the \_\_\_\_\_. Apparently, as a result of this fall injuries to the right shoulder, lumbar spine and right knee were sustained.

An MRI of the right shoulder on 06/21/01 is remarkable for hypertrophic changes at the acromioclavicular joint primarily. No definite rotator cuff tear is identified.

A doctor \_\_\_\_\_ submits a pre-authorization request dated 08/17/01. He requests pre-approval of 18 sessions of physical medicine. On 08/22/01, \_\_\_\_\_ pre-approves twelve (12) sessions of care, authorization #AP79503. The claimant begins a course of care on 09/10/01 with a pain level of 07/10 on the visual analog scale. Objective findings primarily consist of restricted range of motion of the areas of interest. Treatment consists of soft tissue mobilization, myofascial release, peripheral joint mobilization, therapeutic procedures and therapeutic exercises. This format continues through 10/12/01. On this date documentation reflects that the claimant is unchanged and continues with a pain level of 7/10 on the visual analog scale. Her complaints are identical to previous notes. Her back pain disability score is 72%. Objective findings are identical to the previous notes. Treatment rendered is also identical.

On 10/08/01 the claimant sees a \_\_\_\_\_ for an orthopedic consult. His assessment is that of an impingement syndrome. He feels that the claimant would benefit from either injections or manipulation under anesthesia and arthroscopy of the right shoulder. The claimant is against any injections but accepts surgical intervention.

On 10/12/01 the claimant apparently undergoes counseling. The hand written note is difficult to interpret but it appears that she is suffering from depression.

The attending continues care beyond the pre-approved twelve (12) sessions. Combined passive modalities and active exercises continue through October and November of 2001.

On 12/17/01 the claimant undergoes arthroscopic subacromial decompression with examination of the glenohumeral joint and manipulation under anesthesia. The attending is \_\_\_\_\_. The claimant is seen in follow up by \_\_\_\_\_ on 12/17/01. He notes that her range of motion should be better. The claimant is to start physical therapy. \_\_\_\_\_ emphasizes range of motion exercises followed by rotator cuff strengthening. He places no restrictions regarding her right shoulder. On 01/14/02 \_\_\_\_\_ sights disappointment with the claimant's progress. The claimant reports to the

physician that she has had only two (2) sessions of physical therapy. \_\_\_\_ comments “this appears to be a pattern with this patient since I also tried offering other treatments to the patient, such as shoulder injections; however her anxiety and fears prevented such treatment.” “Whether it is anxiety and fear or insurance carrier denials for the needed therapy, it is the delay of initiating therapy that is now necessitating manipulation under anesthesia.”

The claimant continues with passive and active care under the direction of \_\_\_\_\_. On 02/11/02 she undergoes manipulations under anesthesia of the right shoulder and injection of the subacromial space. The claimant follows with \_\_\_\_ on 02/13/02 and is reportedly very upset with her lawyer and with the manipulations under anesthesia. She did not attend therapy on 02/12/02, as instructed by \_\_\_\_\_, due to nauseousness. Her pain level is an 8/10 on the visual analog scale. Objective findings are essentially unchanged. Treatment continues to include soft tissue mobilization, myofascial release, joint mobilization and therapeutic exercises.

The claimant sees \_\_\_\_ on 03/11/02 and remains limited in her range of motion. He apparently is not pleased with her progress thus far. His recommendations are an MRI of the cervical spine and epidural steroid injections to the lumbar spine. He does not feel that the claimant’s shoulder warrants another manipulation under anesthesia at this time.

### **Requested Service(s)**

According to the documentation, the claimant underwent twenty-six (26) sessions of physical medicine between 09/10/01 and 02/15/02. Services included: therapeutic procedures (one on one), reports, therapeutic procedures (group), myofascial release, joint mobilization, and electrical muscle stimulation.

### **Decision**

1. I disagree, in part (see below), with the insurance carrier in that the services from 09/10/01 through 10/12/02 were medically reasonable and necessary.
2. I agree with the carrier in that the chiropractic services from 10/18/01 through 02/08/02 were medically unreasonable and unnecessary.
3. I disagree, in part, with the carrier in that the six dates of service from 02/13/02 through 02/15/02 were medically reasonable and necessary. Six sessions of “group” exercises, perhaps two units per session should have sufficed. I saw no medical need for a return to passive care.

### **Rationale/Basis for Decision**

1. On 08/17/01 the attending submitted a formal request for pre-authorization of eighteen (18) sessions of conservative physical medicine. On 08/22/01 \_\_\_\_\_ approved twelve (12) sessions of care. In all likelihood a physician advisor was consulted regarding the request and his professional recommendation was implemented. I defer to his opinion regarding the dates of service from 09/10/01 through 10/12/02. The pre-authorization notice (Number AP79503) should be strictly adhered to. Having said this, it is my opinion that the extensive use of “one on one” therapeutic procedures was medically unnecessary. With appropriate initial instruction this claimant should have graduated to a group setting

of therapeutic procedures/exercises. I saw no need for “one to one” interaction over a four week period. The extensive use of passive modalities was also questionable. Reportedly, this claimant had seven (7) months of passive modalities prior to beginning the rehabilitation program. In my opinion, four (4) to six (6) sessions of “one on one” therapeutic procedures and passive modalities should have sufficed.

2. This claimant showed little to no progression with the care that was rendered. Documented subjective and objective progression is a requirement for the continued utilization of physical medicine, as per TWCC Treatment Guidelines. The lack of progression fails to substantiate the continuation of care. The visits from 10/18/01 through 02/08/02 were medically unnecessary.
3. The claimant underwent a manipulation under anesthesia procedure on 02/11/02. Obviously the procedure was pre-approved. As per manipulation under anesthesia protocols, a period of post procedural rehabilitation is appropriate. Given the fact that the claimant had already undergone a minimum of six weeks of pre-procedural rehabilitation, I saw no need for a return to the extent of therapy that was previously utilized. Six sessions of “group” exercises, perhaps two units per session should have sufficed. I saw no medical need for a return to passive care.

The opinions rendered in this care are the opinions of this evaluator. This evaluation has been conducted on the basis of medical documentation as provided with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports, or reconsideration may be requested. Such information may or may not change the opinions rendered in this evaluation. This opinion is based on a clinical assessment from the documentation provided. This opinion does not constitute, per se, a recommendation for specific claims or administrative functions to be made or enforced.