

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, 133.307 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 09-02-03. Per Rule 133.308(e)(1) dates of service 08-01-02 through 08-30-02 were not timely filed.

The IRO reviewed vasopneumatic treatments, electrical stimulation, outpatient visits, office visits with manipulation, therapeutic procedures, therapeutic exercises and therapeutic activities rendered from 09-03-02 through 04-08-03 that was denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that the requestor **did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the IRO fee.

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. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 11-21-03, 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:

The respondent addressed date of service 09-03-02 code 99213-MP per explanation of benefits and payment has been made per the fee schedule per check number 05418503. Therefore, no fee issues exist for this date of service.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS	Reference	Rationale
10-15-02	97016	\$60.00 (2 units)	\$0.00	D	\$24.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement of \$48.00 (\$24.00 X 2) recommended.
10-15-02	97032	\$60.00 (2 units)	\$0.00	D	\$22.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement of \$44.00 (\$22.00 X 2) recommended.
10-15-02	99213-MP	\$38.00 (1 unit)	\$0.00	F	\$48.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement of \$38.00 recommended.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS	Reference	Rationale
TOTAL		\$158.00	\$0.00		\$140.00		The requestor is entitled to reimbursement in the amount of \$130.00

### 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 Decision is applicable for dates of service 8-28-01 through 12-28-01 in this dispute.

This Findings and Decision and Order are hereby issued this 15<sup>th</sup> day of March 2004.

Debra L. Hewitt  
 Medical Dispute Resolution Officer  
 Medical Review Division  
 DLH/dlh

### NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** March 10, 2004

**MDR Tracking #:** M5-04-0029-01

**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 Chiropractic physician reviewer that has ADL certification. The Chiropractic 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**

According to the documentation presented, the claimant allegedly injured his left posterior shoulder and neck on \_\_\_ while lifting boxes as part of his occupation. Initial x-rays were negative. Following the injury, the claimant was unable to perform all of his occupational duties, so he was taken off work and underwent 6 weeks of chiropractic therapy. Following the therapy, the claimant was still unable to perform all of the duties of his occupation. An MRI of the left shoulder dated 07/12/02 was negative. The claimant continued off work and under chiropractic therapy over the following three months. He had an

orthopedic consult on 10/30/02 and was given a corticosteroid injection in the left shoulder. An FCE conducted on 12/17/02 suggested that the claimant undergo 6 weeks of work hardening.

**Requested Service(s)**

I have been asked to present a decision regarding the medical necessity of outpatient services, specifically vasopneumatic treatment, electrical stimulation, out-patient visits, office visits with manipulation, therapeutic procedures, therapeutic exercises, and therapeutic activities rendered to the claimant from 09/03/02 through 04/08/03.

**Decision**

Treatment rendered to the claimant from 09/03/02 through 04/08/03 including vasopneumatic treatments, electrical stimulation, outpatient visits, office visits with manipulation, therapeutic procedures, therapeutic exercises, and therapeutic activities were not medically necessary.

**Rationale/Basis for Decision**

Prior to 09/03/02 the claimant had already undergone 12 weeks of chiropractic therapy, the bulk of which was at a three visit per week frequency. By current and accepted standards of care, the frequency and duration of chiropractic therapy prior to 09/03/02 was more than adequate to treat the claimant's soft tissue strain injury with negative MRI findings. The documentation contains no objective information to support or justify any continued chiropractic therapy beyond 08/30/02.

**LITERARY SOURCES:**

<http://www.chiroweb.com/archives/20/22/04.html> "Managing Shoulder Sprain/Strain Injuries", Kim Christensen, DC, DACRB, CCSP, CSCS

Rehabilitation of the Spine, Liebenson, Craig, D.C., et al, Williams & Wilkins, Baltimore, MD, 1996.