

MDR Tracking Number: M5-04-0393-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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 10-8-03.

The IRO reviewed ultrasound therapy, myofascial release, physical medicine treatment, office visits w/manipulations, kinetic activities, therapeutic procedures, and special reports from 7-3-03 through 9-5-03 that were denied as not medically necessary.

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 \$460.00** 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.

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

On 12-15-03, 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.

Requestor billed CPT codes 97140 and 98941 on 8-4-03, 8-5-03, 8-7-03, 8-12-03, 8-20-03, 8-21-03, 8-22-03, 9-2-03, 9-3-03, and 9-5-03. These two codes are not recognized by the 1996 *Medical Fee Guideline*; therefore, no review will be conducted for these two codes.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
7/8/03 7/10/03 7/14/03	97035 99213MP 97010 97250 97014	\$50.00x4 \$60.00x2 \$50.00x2 \$45.00x2 \$25.00x2	\$0.00	F,C	\$22.00 ea 15 min \$48.00 \$11.00 \$43.00 \$15.00	Rule 133.307(g)(3) (A-F)	Requestor did not challenge the carrier's denial and neither party submitted a copy of the negotiated contract; therefore, the MRD cannot determine a fee reimbursement.
8-4-03 8-5-03 8-7-03	97530 97110	\$90.00x3 \$70.00x3	\$0.00	D	\$35.00 ea 15 min \$35.00 ea 15 min	Rule 133.307(g)(3) (A-F)	97530. Relevant information supports delivery of service. Recommend reimbursement of \$70.00 x 3 = \$210.00. 97110. See RATIONALE below.
TOTAL		\$940.00	\$0.00				The requestor is entitled to reimbursement of \$210.00.

RATIONALE: Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one". Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division (MRD) has reviewed the matters in light of the Commission requirements for proper documentation.

The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

The above Findings and Decisions are hereby issued this 11th day of March 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

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 Order is applicable for dates of service 7-3-03 through 9-5-03 in this dispute.

This Order is hereby issued this 11th day of March 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

Enclosure: IRO Decision

MEDICAL REVIEW OF TEXAS
3402 Vanshire Drive **Austin, Texas 78738**
Phone: 512-402-1400 **FAX: 512-402-1012**

NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISED 3/2/04

TWCC Case Number:	
MDR Tracking Number:	M5-04-0393-01
Name of Patient:	
Name of URA/Payer:	Jeffrey S. Standifer, DC
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician:	Jeffrey S. Standifer, DC
(Treating or Requesting)	

December 8, 2003

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Texas Workers Compensation Commission

CLINICAL HISTORY

Ms. ____, a 32-year-old female, sustained an on the job injury while working at JP Morgan Chase performing data entry for the senior operations department. On the date of injury, she was repetitively and rapidly stamping with a metal stamper, using her left-hand. As she was doing this, she felt a pop or jerk in the left shoulder. She continued working and later that day felt a subsequent pop. She developed pain in her shoulder and upper back area with pain extending into the left arm, and so reported the injury to a supervisor. She was advised to use the opposite arm which she did, and continuing at work for further two weeks before seeking medical assistance with an orthopedic, upper extremity specialist, Dr. Boulas. Presenting complaints were predominately left shoulder pain with aching pain across the cervico-thoracic area into the right shoulder, and down into the interscapular region. Dr. Boulas felt that she had an impingement syndrome. He continued her at work with limitations and referred her to physical therapy. She failed to improve and in fact worsened so she requested a change of treating doctors to Dr. Jeffrey Standifer, a chiropractor who saw her on 5/23/03. His impression following exam and x-ray was bilateral shoulder and wrist pain as well as neck pain. MRI's of both shoulders were obtained, the left MRI revealed some minimal changes in the supraspinatous tendon suggestive of a small partial tear of the rotator cuff. The right MRI was normal. In patient had a neurological consult on 6/9/03 with EMG/NCV studies. These identified some changes of the left scapula and upper arm muscles suggestive of C5 nerve root irritation at the brachial plexus level. The patient had an IME on 7/35/03 by in an orthopedic surgeon, George Armstrong, M.D. who felt that the patient had had appropriate care up

however failed to be responding and recommended referral for orthopedic evaluation for diagnostic/therapeutic subacromial injections, possibly with the addition of any intraarticular injections and/or arthroscopic evaluation. Dr. Standifer performed a FCE on the patient in on 7/31/03. This appears to be more of a functional evaluation of the left shoulder and with wrist and cervical range motion additionally evaluated. No work capacity information was reported, recommendation for referral to orthopedic specialist was concluded. The patient followed-up with Marvin Van Hal, M.D. an orthopedist specializing in upper extremity disorders on 8/13/03. He felt that she had an impingement syndrome on the left shoulder in addition to a cervical strain. He recommended / performed a subacromial injection. She was then referred for work hardening following a second FCE on 9/8/03. Although she was functioning at a light physical demand capacity level, significant deficits with use of the left arm were identified. She underwent four weeks of work hardening.

Various services have been denied for payment between the dates 07/03/03 through 09/05/03, based on medical necessity and is thus referred for medical dispute resolution purposes through the IRO process.

REQUESTED SERVICE(S)

Ultrasound therapy, myofascial release, physical medicine treatment, office visits w/manipulations, kinetic activities, therapeutic procedure and special reports for dates of service 7/3/03 through 9/5/03.

DECISION

All the provided services were medically necessary for the care of this patient.

RATIONALE/BASIS FOR DECISION

The patient has undergone appropriate care measures, including subacromial injection and work hardening, for an obviously difficult and complicated problem that had failed to response to initial conservative care measures. Initial pain rating scores were 8/10 bilaterally in the shoulders, 9/10 for neck pain and 5/10 bilaterally for wrist pain. On 9/5/03 these scores had dropped to 1/10 for shoulders and neck, 0/10 for wrists. She appeared to be progressing well with her exercise program.

The current standard of medical necessity in Workers Comp, according to the Texas labor code 408.021 (entitlement to medical benefits), is that an employee who sustained a compensable injury is entitled to all healthcare reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to healthcare that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment.

The standard of medical necessity, as required by 408.021 has more than adequately been met in this particular case.

The above analysis is based solely upon the medical records/tests submitted. It is assumed that the material provided is correct and complete in nature. If more information becomes available at a later date, an additional report may be requested. Such and may or may not change the opinions rendered in this evaluation.

Opinions are based upon a reasonable degree of medical/chiropractic probability and are totally independent of the requesting client.

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.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar 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 or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

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

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 2nd day of March 2003.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell