

MDR Tracking Number: M5-04-0967-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 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 12-02-03.

The Medical Review Division has reviewed the IRO decision and determined that the requestor **did not prevail** on the issues of medical necessity. The IRO reviewed office visits rendered from 12-02-02 through 01-07-03 denied for medical necessity based upon "U". 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 02-23-04, 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	Reference	Rationale
12-2-02 through 12-11-02 (5 DOS)	97035	\$130.00 (1 unit @ \$26.00 X 5 DOS)	\$0.00	F	\$22.00	Rule 133.307 (g)(3)(A-F)	The requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$22.00 X 5 DOS = \$110.00
12-20-02 through 1-7-03 (6 DOS)	97035	\$156.00 (1 unit @ \$26.00 X 6 DOS)	\$0.00	N	\$22.00	96 MFG MEDICINE GR (I)(10)(b)	The requestor submitted relevant information to meet documentation criteria. Reimbursement recommended in the amount of \$22.00 X 6 DOS = \$132.00
12-2-02 through 12-11-02 (5 DOS)	97014	\$90.00 (1 unit @ \$18.00 X 5 DOS)	\$0.00	F	\$15.00	Rule 133.307 (g)(3)(A-F)	The requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$15.00 X 5 DOS = \$75.00

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS	Reference	Rationale
12-20-02 through 1-7-03 (6 DOS)	97014	\$108.00 (1 unit @ \$18.00 X 6 DOS)	\$0.00	N	\$15.00	96 MFG MEDICINE GR (I)(10)(b)	The requestor submitted relevant information to meet documentation criteria. Reimbursement recommended in the amount of \$15.00 X 6 DOS = \$90.00
12-2-02 through 12-11-02 (5 DOS)	97010	\$75.00 (1 unit @ \$15.00 X 5 DOS)	\$0.00	F	\$11.00	Rule 133.307 (g)(3)(A-F)	The requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$11.00 X 5 DOS = \$55.00
12-20-02 through 1-7-03 (6 DOS)	97010	\$90.00 (1 unit @ \$15.00 X 6 DOS)	\$0.00	N	\$11.00	96 MFG MEDICINE GR (I)(10)(b)	The requestor submitted relevant information to meet documentation criteria. Reimbursement recommended in the amount of \$11.00 X 6 DOS = \$66.00
TOTAL		\$649.00	\$0.00				The requestor is entitled to reimbursement in the amount of \$528.00

### 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 12-02-02 through 01-07-03 in this dispute.

This Findings and Decision and Order are hereby issued this 30<sup>th</sup> day of April 2004.

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

## NOTICE OF INDEPENDENT REVIEW DECISION

February 18, 2004

MDR Tracking #: M5-04-0967-01  
IRO Certificate #: IRO 4326

The \_\_\_ 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 rendered 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 matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. \_\_\_ health care professional 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 patient injured his left shoulder on \_\_\_ while lifting a trashcan partially filled with water. An MRI dated 11/06/02 revealed tendonitis of the rotator cuff tendon and the presence of some fluid. He was referred to an orthopedic surgeon who stated clinically the patient has a rotator cuff tear.

### Requested Service(s)

Office visits from 12/02/02 through 01/07/03

### Decision

It is determined that the office visits from 12/02/02 through 01/07/03 were not medically necessary to treat this patient's condition.

### Rationale/Basis for Decision

The reviewed documentation indicates that this patient's injury can easily be classified within the strain/sprain treatment model. Typical treatment duration of a strain/sprain injury is four to eight weeks. During this treatment period, it is customary for rehabilitation applications to become increasingly more active and patient-driven. The provider implemented nearly the same treatment from 12/02/02 through 01/07/03. It is not clear why office visits were utilized on every treatment. There was no change in functional status, new programs were not introduced, and no new diagnostics were performed to warrant the use of office visits. Therefore, it is determined that the office visits from 12/02/02 through 01/07/03 were not medically necessary.

The aforementioned information has been taken from the following guidelines of clinical practice and clinical references:

- Etty-Griffin MD PhD, LY. *Neuromuscular Training and Injury Prevention in Sports*. Clinical Orthopedics and Related Research 2003; 409:53-60.
- Ludewig PM, Cook TM. *Alterations in shoulder kinematics and associated muscle activity in people with symptoms of shoulder impingement*. Phys Ther 200 Mar;80(3):276-91.
- *Overview of implementation of outcome assessment case management in the clinical practice*. Washington State Chiropractic Association; 2001. 54p.
- Yeomans DC, SG. *Applying Outcomes Management into Clinical Practice*. J Neuromusculoskel System Summer 1997; 5(2): 1-14.

Sincerely,