MDR Tracking Number: M5-04-1343-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General 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 01-06-04.

The IRO reviewed office visits and physical therapy treatment, unlisted special service/treatment rendered from 01-08-03 through 03-26-03 that were 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 paid 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 March 22, 2004, 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 insurance carrier denied reimbursement for the following disputed services based upon "W – Not Timely Filed." The TWCC-62 form defines EOB denial code "W" as "Used when HCP has not filed the medical bill by the 1st day of the 11th month following delivery of the t/s." The insurance carrier's EOB denial indicates "Print date of 4-30-03." Therefore, they received the bill within the timeframe outlined on the TWCC-62, and service was incorrectly denied.

DOS	**CPT CODE**	**Billed**	**Paid**	**EOB Denial Code**	**MAR$ (Maximum Allowable Reimbursement)**	**Reference**	**Rationale**
01-06-03	99211	$50.00	$0.00	W	$18.00	TWCC -62	Reimbursement per MFG is recommended of $18.00.
01-06-03	97150 (6)	$40.00 X 6 = $240.00	$0.00	W	$27.00 / 15 min X 6 = $162.00	CPT Code Descriptor	Reimbursement per MFG is recommended of $162.00
TOTAL							The requestor is entitled to reimbursement of **$180.00.**

IV. DECISION & 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 $180.00 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 1-06-03 through 3-26-03 in this dispute.

The above Findings, Decision and Order are hereby issued this 19th day of August 2004.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

March 19, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-1343-01
IRO Certificate #: 5348

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 50 year-old male who sustained a work related injury ___. The patient reported that he was a passenger in a semi truck when it ran off the road. The patient reported that he was thrown around in the sleeper of the semi. The patient reported being seen in the emergency room. Radiographs dated 11/28/01 of the patient's right shoulder and mandible showed no significant bony abnormality in the right shoulder and a normal mandible. On 12/1/01 the patient presented to the emergency room with complaints of a headache and was diagnosed with a neck injury (cervical strain) and a mild head injury. On 12/10/01 the patient

was evaluated by his current treating chiropractor and underwent x-rays of the cervical spine and right shoulder. The diagnoses for this patient included acute post traumatic rotator cuff syndrome of shoulder and allied disorders, acute post traumatic headache related to cervical trauma, spasm of muscle, sleep disturbances, contusion to face, and acute post traumatic dysfunction of the TMJ. The patient began a course of treatment that included joint mobilization, massage treatments, myofacial release treatments, and electro-stimulation. The patient underwent further diagnostics including MRIs of the cervical spine and right shoulder and electro diagnostic studies. On 6/14/02 the patient underwent a right shoulder arthroscopy with anterior superior labral debridement, right subacromial decompression and resection of the right distal clavicle. Postoperatively the patient was treated with physical therapy.

Requested Services

Office visits evaluation/management est. pt., therapeutic exercises, therapeutic procedures, unlisted special service/report from 1/8/03 through 3/26/03.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is upheld.

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a 51 year-old male who sustained a work related injury to his neck on ___. The ___ chiropractor reviewer indicated that the patient began receiving chiropractic treatment on 12/10/01 for the diagnoses of posttraumatic rotator cuff syndrome, acute posttraumatic headaches related to the cervical trauma, spasms and sleep disturbances, restricted cervical spine and shoulder range of motion, and several positive orthopedic tests and tenderness to palpation. The ___ chiropractor reviewer noted that treatment for this patient's condition included therapeutic procedures, therapeutic exercises, range of motion tests, muscle tests, and surface electro myography. However, the ___ chiropractic reviewer explained that the records provided failed to show a treatment plan, objective findings, evidence of change in treatment or resolution to the patient's condition. The ___ chiropractor reviewer noted that the patient was treated with several different modalities, long term care, and exercise sessions for well over one year with no change in complaints, findings and diagnoses. The ___ chiropractor reviewer explained that the patient's treatment had exceeded a reasonable prognosis and has surpassed the guidelines expressed in the American College of Orthopedic Environmental Medicine, the Milliman Care Guidelines, Ambulatory Care, 8th edition, and the Mercy Guidelines. The ___ chiropractor reviewer also explained that the patient could have been transitioned to a home independent exercise program. The ___ chiropractor reviewer noted that the patient had also received electro diagnostic testing. However, the ___ chiropractor reviewer explained that the American Association of Electrodiagnostic Medicine advised that there are no clinical indications for the use of SEMG in the diagnosis and treatment of disorders of nerve or muscle. Therefore, the ___ chiropractor consultant concluded that the office visits evaluation/management est. pt., therapeutic exercises, therapeutic procedures, unlisted special service/report from 1/8/03 through 3/26/03 were not medically necessary to treat this patient's condition.

Sincerely,