

MDR Tracking Number: M5-04-1798-01

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 February 18, 2004.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. The electrical stimulation, manual therapy-tech, office visit and therapeutic exercise from 11-19-03 through 11-20-03 were found to be medically necessary. 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 May 5, 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:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Max. Allowable Reimbursement)	Reference	Rationale
11-19-04	99214	\$100.58	\$0.00	N,F	\$111.15	Medicare Fee Schedule, CPT code discriptor	Relevant information submitted by the requestor supports documentation criteria and delivery of service billed. Therefore, the disputed service will be reviewed according to Medicare Fee Guideline, Rule 134.202 (d). Recommend reimbursement of \$100.58.
TOTAL							The requestor is entitled to reimbursement of \$100.58.

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) and in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (b); 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 from 11-19-03 through 11-20-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 8<sup>th</sup> day of October 2004.

Patricia Rodriguez  
Medical Dispute Resolution Officer  
Medical Review Division

PR/pr

April 30, 2004

Rosalinda Lopez  
Texas Workers' Compensation Commission  
Medical Dispute Resolution  
Fax: (512) 804-4868

Re: Medical Dispute Resolution  
MDR #: M5-04-1798-01  
IRO Certificate No.: IRO 5055

Dear Ms. Lopez:

\_\_\_ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, \_\_\_ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of \_\_\_ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine who is currently on the TWCC Approved Doctor List.

## **REVIEWER'S REPORT**

### **Information Provided for Review:**

TWCC-60, Table of Disputed Services & EOB's

H&P 03/17/04

Chiropractic and orthopedic notes 09/11/03 – 11/19/03.

Operative report 09/30/03, MRI 07/23/03

### **Clinical History:**

This claimant is a 49-year-old female who was involved in a work-related injury on \_\_\_\_\_. This claimant was sent to the company physician who took a radiograph series of the left shoulder, initiated physical therapy services, and returned to claimant to light duty status. Left shoulder arthroscopy was performed by Dr. F on 07/15/02 and on 12/09/02. MR imaging of the left shoulder performed on 10/10/02 revealed evidence of moderate tendinosis involving the central portion of the distal rotator cuff. MR imaging of the left shoulder performed on 07/23/03 revealed that the claimant had a focal full-thickness tear of the rotator cuff tendon centrally at the insertion onto the greater tuberosity of the humerus on 09/30/03, the claimant had a left shoulder rotator cuff repair, left shoulder subacromial decompression, and a capsular shift of the left shoulder.

### **Disputed Services:**

Electrical stimulation, manual therapy-tech, office visit and therapeutic exercise during the period of 11/19/03 through 11/20/03.

### **Decision:**

The reviewer disagrees with the determination of the insurance carrier and is of the opinion that the services and therapy in dispute as stated above was medically necessary in this case.

### **Rationale:**

The reviewed medical record reveals that the claimant has had a history of shoulder surgeries that included arthroscopic procedures on 07/15/02 and 12/09/02. The claimant's most recent surgery was on 09/30/03, and the claimant had a left shoulder rotator cuff repair, left shoulder subacromial decompression, and a capsular shift of the left shoulder. Reviewed medical record does show a need for rehabilitation applications following the 09/30/03 surgery. The provider's services from 11/19/03 through 11/20/03 are necessitated due to the temporal proximity to the 09/30/03 surgery.

It is necessary for the claimant to undergo a time-limited course of passive applications with a noticeable trend into active, patient-driven therapeutics. After the 10/16/03 evaluation by the treating surgeon, the claimant was advised to initiate rehabilitation in about 4 weeks.

The aforementioned information has been taken from the following guidelines of clinical practice and/or peer reviewed references.

- *Criteria For Shoulder Surgery*. Washington State Department of Labor and Industries; 2002 MAR 4 p.
- McMahon, P J, et. al. *Muscles May Contribute to Shoulder Dislocation and Instability*. Clin Orthop 2002 OCT; (403 suppl): S 18-25  
Potcl, W., et. al. *Proprioception of the Shoulder Joint After Surgical Repair for Instability; A Long Term Followup Study*. Am J of Sports Medicine. 2002. 32: 425-430.

Sincerely,