

MDR Tracking Number: M5-04-2272-01

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 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 9-3-03.

Dates of service prior to 9-3-02 were not considered because they were submitted untimely per Rule 133.308.

The IRO reviewed the medical necessity of office visits, joint mobilization, myofascial release, manual traction, therapeutic exercises, replacement batteries, durable medical equipment, physical performance testing and non-emergency transportation rendered from 9-6-02 through 5-29-03 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(r)2(C), the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

The IRO concluded that evaluation/management codes, joint mobilization (97265), myofascial release (97250), manual traction (97122) and therapeutic exercises (97110) were medically necessary from DOS 3-21-03 through 4-21-03. The IRO concluded that all other treatment were not medically necessary.

On this basis, the total amount recommended for reimbursement (\$2635.00) does not represent a majority of the medical fees of the disputed healthcare and therefore, the requestor did not prevail in the IRO decision. 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.

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

On September 9, 2003, 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:

No EOB: Neither party in the dispute submitted EOBs for some of the disputed services identified below. The requestor did not submit convincing evidence that supports bills were submitted for audit per Rule 133.307(e)(2)(B); therefore, they will not be considered further in this decision.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
9-4-03 9-18-03	97265	\$43.00	\$0.00	No EOB	NRF		These dates of service were performed after the dispute was received in MDR; therefore, are not eligible for review in this dispute.
9-4-03 9-18-03	97250	\$43.00	\$0.00	No EOB	NRF		
9-4-03 9-18-03	97122	\$35.00	\$0.00	No EOB	NRF		

9-4-03	99213	\$48.00	\$0.00	No EOB	\$66.19 or less		
9-6-03	99080-73	\$15.00	\$0.00	F	\$15.00		
9-18-03	97100	\$105.00	\$0.00	No EOB	NRF		
3-31-03	97100	\$105.00	\$0.00	No EOB	Unrecognized code		
11-27-02	99213	\$48.00	\$0.00	No EOB	\$48.00	CPT Code Descriptor	As stated above, no reimbursement is recommended.
9-20-02	J1030	\$45.00	\$0.00	M	DOP	Rule 133.307(g)(3)(D) Section 413.011(d)	Requestor did not support amount billed was fair and reasonable and complied with statute.
9-20-02	J2000	\$30.00	\$0.00	M	DOP		
9-20-02	20550	\$40.00	\$0.00	F	\$40.00	CPT Code Descriptor	MAR reimbursement of \$40.00 is recommended.
9-20-02	20550	\$60.00	\$0.00	F	\$40.00	CPT Code Descriptor	MAR reimbursement of \$40.00 is recommended.
9-30-02	72050	\$160.00	\$0.00	D	\$81.00		This is a duplicate X-ray billing, no reimbursement is recommended.
9-30-02	72050	\$200.00	\$0.00	F	\$81.00		MAR reimbursement of \$81.00 is recommended.
9-30-02	A0100	\$17.00	\$0.00	G	DOP	Non-Emergency Transportation	Report does not indicate why service was rendered and why it is not global to any other service rendered, DOP was not met; therefore, reimbursement is recommended.
3-11-03	99090	\$108.00	\$0.00	No EOB	\$108.00	CPT Code Descriptor	As stated above, no reimbursement is recommended.
3-11-03	97750	\$500.00	\$0.00	No EOB	\$100.00/hr	CPT Code Descriptor	
4-16-03	A0100	\$17.00	\$0.00	No EOB	DOP	CPT Code Descriptor	
TOTAL							The requestor is entitled to reimbursement of \$161.00.

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 9-3-02 through 5-29-03 in this dispute.

This Order is hereby issued this 19th day of January 2005.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

SECOND AMENDED DECISION

Date: November 10, 2004

RE:

MDR Tracking #: M5-04-2272-01

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 reviewer who has an ADL certification. The 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.

Submitted by Requester:

- Notes, ___
- Electrodiagnostic studies, 7/18/02
- Right shoulder MRI, 6/12/03
- Right shoulder and right wrist MRIs, 9/5/02
- Chiropractic and/or physical therapy notes, unsigned
- Notes, ___
- Shoulder diagnostic ultrasound reports, multiple
- Notes, ___
- Notes, ___
- Lumbar MRI, 5/3/04
- Notes, ___

Submitted by Respondent:

- None

Clinical History

The claimant, ___, allegedly received injury to the right shoulder region while performing occupational duties for her employer on ___. However, the claimant apparently had right wrist surgery in 5/02 and subsequent right shoulder surgery on 1/28/03.

It appears that the claimant has been treated with passive and active care to include both areas on an almost constant basis, through at least 11/03, when a secondary shoulder surgery was performed. Records indicate that this claimant continued to have subjective pain complaints at moderate levels for the wrist area and the shoulder area.

On 9/05/02, MRI testing was performed on both right shoulder and right wrist area with impressions noted as MRI Right Shoulder: (1) moderate to prominent degree soft tissues AC joint hypertrophy without true effusion identified. Densities indent anterosuperior distal supraspinatus musculature contours and further clinical correlation is suggested as these findings maybe associated with impingement. MRI Right Wrist: (1) anatomically, a smaller carpal tunnel including “crowding” of flexor tendons within, anterior bowing of the flexor retinaculum, and comparative prominence of the median nerve within the tunnel. Clinical correlation is suggested, as these findings maybe associated with a clinical carpal tunnel syndrome.

On 6/12/03, a post-surgical MRI of the right shoulder was performed with impressions noted as MRI Right Shoulder: (1) status post surgery in the acromioclavicular joint region, probably an acromioplasty, (2) subdeltoid / subacromial bursitis and (3) supraspinatus tendinosis, with no apparent full thickness rotator cuff tear.

Progress report dated 10/13/03 denotes that the claimant’s right shoulder pain complaints had not been relieved by conservative treatment including non-steroidal anti-inflammatory medications, surgery, and physical therapy. Therefore, a second surgery was recommended.

Daily treatment notes were reviewed for this IRO decision process for DOS 9/06/02 through 5/29/03.

Requested Service(s)

Please review and address the medical necessity of the outpatient services to include 92213 (level III office visits), 97265 (joint mobilization), 97250 (myofascial release), 97122 (manual traction), 97110 (therapeutic exercises), A4630 (replacement batteries), E1399 (durable medical equipment (DME)), 97750 (physical performance testing (PPE)), and A0100 (non-emergency transportation); denied by carrier for medical necessity the “U” codes on the above mentioned claimant for dates of service (DOS) 9/06/02 through 5/29/03.

Decision

I disagree with the insurance company and find that evaluation/management (E/M) codes 97265 (joint mobilization), 97250 (myofascial release), 97122 (manual traction), and 97110 (therapeutic exercises) were medically necessary for DOS 3/21/03 through 4/21/03.

I agree with the insurance company that the remainder of services rendered were not medically necessary.

Rationale/Basis for Decision

As best that can be determined, this claimant received surgical procedures to the right wrist in 5/02, subsequent injury to right shoulder in ___ and surgical procedure to right shoulder again, on 1/28/03. DOS in question reports both wrist and shoulder treatment continued throughout this time frame with

waxing and waning of wrist area, subjective complaints, and no real improvement noted to the shoulder region and in fact, resulting in a 2nd surgical procedure.

It would be usual and customary for post surgical rehabilitation, concerning the shoulder area. Even though it appears to be started rather late (approx. 6 weeks post), a 4 week trial period would be reasonable. Review of the documentation does not reveal that this claimant was making objective clinical progress. Pain levels for the most part remained between 7-10. Subjective complaints did not appear favorable and objective findings did not reveal progressive change. The rationale to continue this type of involved therapy despite what actually amounted to a worsening effect (i.e. complaints of sharp pain, grindings, etc.) which later ended in a 2nd surgical procedure, with rotator cuff tear diagnosis, is not completely understood. It is my opinion this claimant could have been independent with an home exercise program (HEP) and self administered pain relieving techniques to maintain a pre-surgical environment. Obviously, medication intake remained with orthopedic follow-up visits throughout the time frame up through the 2nd shoulder surgical procedure. No extra benefit was revealed to demonstrate the necessity for clinically supervised therapy over that of an HEP after this 4 week trial period, and 12 weeks post-surgical event. What is surprising is that therapy procedures did not change when these new subjective complaints began on or about 3/13/03 and this possibly made the condition worse.

Concerning codes 97265 (joint mobilization), 97250 (myofascial release), 97122 (manual traction), 97110 (therapeutic exercises): review of the treatment notes does not indicate that current therapy was benefiting this claimant in a significant progressive manner. Pain levels were relatively consistent and severe to extreme, in the shoulder region. Objective findings do not support a clinically supervised program, especially this involved, without progress benefit.

Concerning code 99213 (level III OV): documentation does not support this code at this level or frequency for routine and continuing physical therapy. No major changes were recorded in the delivery of this therapy which remained constant throughout this time frame. Medical decision making was directed from the orthopedic doctor's recommendations and the chiropractor was following these recommendations. It is also evident that changes were made according to the follow-up visits to this orthopedic doctor. If one examines the guidelines concerning 99213 (office visits), in terms of history taking, physical exam, and complexity of decision making, this is probably not an appropriate level of E/M for post surgical physical therapy, directed by the MD. Code 99212 is more appropriate at a frequency of every 2 weeks. Again, documentation does not support the need for code 99213 on every visit.

Concerning code E-1399 (misc. DME): again, I failed to find rationale for topical agents in relation to subjective pain complaints. If all the abundance of clinically supervised physical therapy was not improving this claimant's condition it is difficult to ascertain how this treatment was beneficial to this condition, even in terms of relieving qualities or lasting effects. It obviously was not demonstrated throughout the daily treatment notes.

Concerning code A-4630 (batteries): this service would not be necessary, if in fact a TENS/NME was not authorized for use or need was not established. It does appear that the service (TENS) was not sought or approval obtained for use, so battery replacement is just a secondary issue with no basis. In any case, after reviewing the documentation pertaining to TENS usage (assuming TENS was utilized by the claimant), I fail to find support for its usage, in terms of documented evidence necessary for its continuation, per TWCC Spine & Extremity Treatment Guidelines,* used as a reference.

I found no objective quantifiable measures of significant or continued improvement, over time. There were no documented reports of decreased muscle spasms or significant decreased pain levels to warrant its use. No record of range of motion (ROM) increase, due specifically to its use. Furthermore, there was no reported decreased medication usage or decrease in physical therapy visits to demonstrate its cost effectiveness.

Result: I find no support for its use for any post surgical complaints in this review.

Concerning specific code A-0100 (non emergency transport): there was absolutely no documentation that supported this service or the reason why this service was logically necessary. It is the treating doctor's responsibility to provide supporting documentation to establish the necessity for such a service in the documentation and since none could be found for this sporadic supplied service due to these injuries it obviously could not be supported for necessity.

Concerning code 97750 (PPE): I would agree with the insurance companies rationale that this test was not reasonable or necessary, if the main objective was to gauge return to work (RTW) issues. An FCE is the test of choice to provide more detailed information and especially, if a more aggressive type program maybe necessary. It also appears that this was not a logical recommendation if one was to examine subjective pain complaints. Level 7-10 complaints were reported pre-testing and even the day of testing, level 10 was reported, including an exacerbation of conditions, and one would expect that test results would not be favorable or as reliable due to these pain factors. This was not a conducive environment for either FCE or PPE testing. Besides, this was approximately 2 weeks post surgical event and it would be difficult to expect results to be that useful, this early post surgery. Pain levels were also still reported high for the 2nd scheduled PPE on 3/11/03 and again, information gathered was probably not that useful. NOTE: *This review did not contain PPE reports.*

* Even though the TWCC Spine & Extremity Treatment Guideline has been abolished, it still remains a reliable reference source to provide guidance, regarding the necessity of treatment.