

MDR Tracking Number: M5-04-2649-01

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. The dispute was received on 4-22-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the majority of 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** 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.

The therapeutic exercises, massage, chiropractic manipulative treatment, manual therapy technique, ultrasound, neuromuscular re-education, supplies and materials, office visits-evaluation and management, expanded and office visit-evaluation and management-self-limited, neuromuscular stimulator, self care/home management training, and mechanical traction from 12-5-03 through 1-28-03 **were found** to be medically necessary. The therapeutic exercises, massage, chiropractic manipulative treatment, manual therapy technique, ultrasound, neuromuscular re-education, supplies and materials, office visits-evaluation and management, expanded and office visit-evaluation and management-self-limited, neuromuscular stimulator, self care/home management training, and mechanical traction from 9-11-03 through 11-2-03 (excluding 10-7-03 through 11-5-03) **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were not the only fees involved in the medical dispute 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 10-07-04 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.

CPT code 97750 for 9-9-03 was denied with a D denial code. Per 133.307 (e)(2)(A): a copy of all medical bills as originally submitted to the carrier for reconsideration in accordance with 133.304 must be submitted for medical fee disputes. **Recommend no reimbursement.**

CPT codes 99082, 98940, 97110, 97035, and 97112 were denied by the carrier with "N" – not appropriately documented. The requester sent no further documentation, SOAP notes or rationale to support these services. **Recommend no reimbursement.**

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees:

- in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c) and 134.202(c)(6);
- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order.

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 Findings and Decision and Order is hereby issued this 5th day of November, 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

July 15, 2004

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking #: M5-04-2649-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) 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 TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF 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 care. TMF's 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 TMF 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 31-year-old male sustained a work related injury _____. He was trying to move a rusted piece of metal, when he felt a sudden jerk in his left shoulder. His left shoulder pain is associated with weakness. On 03/18/03 the patient had an MRI of the left shoulder that revealed a small partial tear of the supraspinatus tendon, no evidence of a full thickness rotator cuff tear, possible tear of the anterior-superior labrum. On 04/01/03 the patient had an arthroscopy for multidirectional shoulder instability to the left shoulder and impingement syndrome to the left shoulder, a thermal capsulorrhaphy, lateral portal was created and subacromial decompression was performed and a spur was removed. The patient was also treated with steroid injections, oral pain medications, physical therapy, functional capacity evaluations, home strengthening exercises, and work hardening program.

Requested Service(s)

Therapeutic exercises (97110), massage (97124), chiropractic manipulative treatment (98940 & 98943), manual therapy technique (97140), ultrasound (97035), neuromuscular re-education (97112), supplies and materials (99070), office visits-evaluation and management, expanded (99213), and office visit-evaluation and management, self limited (99212), neuromuscular stimulator

(E0745), self care/home management training (97535), and mechanical traction (97012) from 09/11/03 through 03/17/04

Please exclude service 97750 (physical performance test-not listed above) on 09/09/03 and dates 10/07/03 through 11/05/03.

Decision

The post-operative treatments from 12-05-03 through 01/28/04 are approved. All other treatments and examinations are denied.

Rationale/Basis for Decision

Daily progress notes were provided; however, these were computer generated and essentially verbatim from day to day. No actual treatment records were supplied. Although the patient was treated on 12/05/03, no mention is made of the shoulder surgery that was performed just one day prior on 12/04/03. Therefore, there is no documentation to support the medical necessity for any treatment prior to 12/05/03.

On the most basic level, the provider has failed to establish why the services performed prior to 12/05/03 were performed in the most cost effective setting. Therapeutic exercises may be performed in a clinic, one-on-one, in a clinic in a group, at a gym or at home. The least costly of these options is for the exercises to be performed at home. A home exercise program is also preferable because the patient can perform them on a daily basis. No justification has been provided for the need for one-on-one therapy. If one-on-one therapy had been medically necessary at some point, it would not have been needed for the duration of the time in this case.

There is also no documentation to support the medical necessity of the treatments prior to 12/05/03 since the care was immediately prior to, concurrent with or immediately following a work hardening treatment.

Solely on the basis that shoulder surgery was performed on 12/04/03, the post-operative rehabilitative treatments beginning on 12/05/03 and ending on 01/28/04 are judged medically indicated.

Sincerely,