

MDR Tracking Number: M5-04-3038-01

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 5-14-04.

The IRO reviewed office visits w/manipulations, joint mobilization, myofascial release, electrical stimulation, hot/cold packs, ultrasound, and manual therapy from 6-6-03 through 9-2-03.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on 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 \$460.00** 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 8-24-04, 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.

- Code 99080-73 was billed for date of service 6-6-03 and denied as "V – unnecessary medical"; however, per Rule 129.5, the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter; therefore, recommend reimbursement of \$15.00.
- Code 97010 was billed for date of service 6-16-03. This code will not be reviewed per the 1996 Medical Fee Guideline, Medicine ground rule I A 10 a which states that a physical medicine session is defined as any combination of four modalities, procedures, and/or physical medicine activities and training. Requestor billed five modalities on this date of service; therefore, code 97010 cannot be considered and no reimbursement recommended.

ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees outlined above as follows:

- In accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003;

- In accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c);
- 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 to dates of service 6-6-03 through 9-2-03 as outlined above 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 4th day of November 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

August 12, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-3038-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
----- Case #:

----- has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ----- 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 who is familiar with the with the condition and treatment options at issue in this appeal. 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 female who sustained a work related injury on -----. The patient presented to the treating physician's office on 1/8/03 for evaluation of continued right shoulder pain as well as right wrist and hand pain. The patient had been treated with cervical spine manipulation, soft tissue mobilization and joint mobilization, interferential stimulation and heat. The patient also underwent a series of cortisone injections. The diagnoses for this patient have included status post right hand carpal tunnel release, right shoulder rotator cuff tendinosis with impingement syndrome, acromioclavicular joint internal derangement, and right wrist flexor carpiulnaris tendonitis. On 8/18/03 the patient underwent right shoulder surgery that consisted of right shoulder arthroscopy with debridement, extensive, including debridement of intra-articular partial thickness rotator cuff tear, arthroscopic subacromial decompression and arthroscopic distal clavicular excision. Postoperatively the patient was treated with a short course of physical therapy and returned to work on 9/15/03.

Requested Services

Office visits with manipulations, joint mobilization, myofascial release, electrical stimulation, hot/cold packs, ultrasound, and manual therapy from 6/6/03 through 9/2/03.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Consults and office visits 1/8/03 – 6/7/04
2. Treatment logs 6/10/02 – 5/12/04
3. Treatment notes 10/24/02 – 9/5/03

Documents Submitted by Respondent:

1. Chiropractic Modality Review 4/10/03
2. Peer Review 3/2/04
3. Treatment log 6/18/03 – 9/2/03
4. Letter 6/6/03

Decision

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

Rationale/Basis for Decision

The ----- chiropractor reviewer noted that this case concerns a female who sustained a work related injury on -----. The ----- chiropractor noted that the patient had experienced exacerbations in her shoulder, both arms and both hands since the original injury date. The ----- chiropractor reviewer indicated that the patient had been treated with chiropractic care and/or injections for these exacerbations. The ----- chiropractor reviewer noted that subsequently the patient underwent surgical intervention. The ----- chiropractor reviewer explained that a trial program of conservative care (4-6 weeks) is medically appropriate to determine if the patient's

pain could be reduced and surgery avoided. The ----- chiropractor reviewer also explained that although the patient did require surgical intervention, postoperative rehabilitation is medically necessary and appropriate. The ----- chiropractor reviewer further explained that the treatment rendered before and after surgery is considered medically necessary. Therefore, the ----- chiropractor consultant concluded that the office visits with manipulations, joint mobilization, myofascial release, electrical stimulation, hot/cold packs, ultrasound, and manual therapy from 6/6/03 through 9/2/03 were medically necessary to treat this patient's condition.

Sincerely,