

MDR Tracking Number: M5-04-3564-01

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 6-21-04.

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** 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 IRO has determined that the myofascial release, joint mobilization, electrical stimulation (unattended), hot/cold pack, office visits, therapeutic exercises, group therapy exercises, manual therapy techniques, and therapeutic activities rendered from 7/11/03-11/19/03 and denied with "V" were medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed service.

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 July 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.

**CPT code 95851** for dates of service 7/1/03 and 8/21/03: Denied by the carrier with the following explanation: "by clinical practice standards, this procedure is incidental to the related primary procedure billed." However, the carrier did not specify what the primary procedure billed was in accordance with Rule 133.304 (c). Since the carrier did not provide a valid basis for this service, **reimbursement is recommended in the amount of \$66.61.**

**CPT code 95931** for dates of service 8/21/03 and 10/24/03: Denied by the carrier with the following explanation: "by clinical practice standards, this procedure is incidental to the related primary procedure billed." However, the carrier did not specify what the primary procedure billed was in accordance with Rule 133.304 (c). Since the carrier did not provide a valid basis for this service, **reimbursement is recommended in the amount of \$68.66.**

**CPT code 97250** for date of service 7/30/03 was denied by the carrier. Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOB's, however, review of the reconsideration HCFAs and certified mail receipt reflected proof of billing in accordance with Rule 133.308 (f)(3). The disputed service will be reviewed according to the 1996 fee guidelines. **Reimbursement is recommended in the amount of \$43.**

**CPT code 97265** for date of service 7/30/03 was denied by the carrier. Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOB's, however, review of the reconsideration HCFAs and certified mail receipt reflected proof of billing in accordance with Rule 133.308 (f)(3). The disputed service will be reviewed according to the 1996 fee guidelines. **Reimbursement is recommended in the amount of \$43.**

**CPT code 97150** for date of service 7/30/03 was denied by the carrier. Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOB's, however, review of the reconsideration HCFAs and certified mail receipt reflected proof of billing in accordance with Rule 133.308 (f)(3). The disputed service will be reviewed according to the 1996 fee guidelines. Reimbursement is recommended in the amount of \$27.

**CPT code 99213** for date of service 10/22/03 was denied by the carrier. Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOB's, however, review of the reconsideration HCFAs and certified mail receipt reflected proof of billing in accordance with Rule 133.308 (f)(3). The disputed service will be reviewed according to the 1996 fee guidelines. **Reimbursement is recommended in the amount of \$59.**

**CPT code 97140** for date of service 7/30/03 was denied by the carrier. Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOB's, however, review of the reconsideration HCFAs and certified mail receipt reflected proof of billing in accordance with Rule 133.308 (f)(3). The disputed service will be reviewed according to the 1996 fee guidelines. **Reimbursement is recommended in the amount of \$30.90.**

**CPT code 97530** for date of service 7/30/03 was denied by the carrier. Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOB's, however, review of the reconsideration HCFAs and certified mail receipt reflected proof of billing in accordance with Rule 133.308 (f)(3). The disputed service will be reviewed according to the 1996 fee guidelines. **Reimbursement is recommended in the amount of \$32.96.**

**CPT code 99080-73** for date of service 10/24/03 was denied by the carrier with "U", unnecessary medical treatment. Proof of billing was submitted in accordance with Rule 133.308 (f)(3).

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 and, therefore, **recommends reimbursement in the amount of \$15**

**CPT code 97140** for dates of service 10/27/03, 10/29/03, 11/3/03, and 11/5/03 was denied by the carrier with "F", and the following explanation: "reimbursement is reduced by the amount

previously paid for another code mutually exclusive to this procedure.” The carrier did not state which procedure this code was “mutually exclusive to” in accordance with Rule 133.304 (c). Since the carrier did not provide a valid basis for this service, **reimbursement is recommended in the amount of \$123.60.**

**CPT code 97110** for date of service 7/30/03: Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MDR declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. **Additional reimbursement not recommended.**

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 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 on or 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 7/1/03 through 11/19/03 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 Decision and Order is hereby issued this 3<sup>rd</sup> day of November 2004.

Regina L. Cleave  
Medical Dispute Resolution Officer  
Medical Review Division

RLC/rlc

September 3, 2004

## NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M5-04-3564-01**  
**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 40 year-old male who sustained a work related injury on ----- . The patient reported that while at work he injured his right shoulder and arm. The patient was initially treated with a 4 week course of physical therapy. The patient returned to work on restrictive duty. He then presented to the treating chiropractor's office and continued with conservative treatment and was diagnosed with a grade II right shoulder sprain/strain and myofascial pain syndrome. The patient was referred out to an orthopedic surgeon and subsequently underwent arthroscopic Bankart lesion repair, subtotal synovectomy, rotator cuff repair through the mini-approach, anterior acromioplasty through the mini-approach, complete bursectomy, and arthroscopic capsulorrhaphy using the ArthroCare wand, right shoulder on 8/26/03. Postoperatively the patient was treated with postoperative physical therapy and rehabilitation.

### Requested Services

Myofascial release, joint mobilization, electrical stimulation unattended, hot/cold pack, office visits, therapeutic exercise, group therapy exercise, manual therapy tech, and therapeutic activities from 7/11/03 through 11/19/03.

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

*Documents Submitted by Requestor:*

1. Summary and Care Explanation
2. Office/Treatment notes 7/1/03 – 11/19/03
3. Therapeutic Procedures Chart 7/18/03 – 11/19/03

*Documents Submitted by Respondent:*

1. Chiropractic Modality Review 9/18/03 and 4/19/04
2. MRI report 7/3/03
3. Office/Treatment notes 7/11/03 – 11/19/03
4. Operative note 8/26/03

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 40 year-old male who sustained a work related injury to his right shoulder and arm on -----. The ----- chiropractor reviewer indicated that the patient was treated with conservative care and a work hardening program until the end of 2/03. The ----- chiropractor reviewer noted that the patient had continued complaints of pain after completing the work hardening program but continued to work. The ----- chiropractor reviewer indicated that the patient was then treated with chiropractic care and subsequently underwent surgery on 8/26/03. The ----- chiropractor reviewer explained that the 4-6 week trial of chiropractic care before surgery is reasonable in attempts to avoid surgery. The ----- chiropractor reviewer also explained that 6-8 weeks of postoperative treatment is reasonable and medically necessary to rehabilitate the patient and return him to work. The ----- chiropractor reviewer indicated that the patient was returned to work to light duty and ultimately was returned to his regular job. The ----- chiropractor reviewer explained that the goal of any treatment program is to return the patient to regular work status. The ----- chiropractor reviewer indicated that the standards of post surgical rehabilitation calls for 8-12 weeks of therapy and that the standards of chiropractic care call for a 6-8 week trial of care to determine its effectiveness. Therefore, the ----- chiropractor consultant concluded that the myofascial release, joint mobilization, electrical stimulation unattended, hot/cold pack, office visits, therapeutic exercise, group therapy exercise, manual therapy tech, and therapeutic activities from 7/11/03 through 11/19/03 were medically necessary to treat this patient's condition.

Sincerely,