

MDR Tracking Number: M5-04-4127-01

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 8-2-04

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that office visits, manual therapy technique, ultrasound, electrical stimulation unattended, paraffin bath and therapeutic procedures from 9-22-03 through 11-17-03 were not medically necessary. Therefore, the requestor is not entitled to a reimbursement of the paid IRO fee.

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 8-27-04 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 99205 on 8-25-03 was denied with an "E" – entitlement to benefits. The BRC of 3-12-04 concluded "The Claimant sustained a compensable, right shoulder, right elbow, and right wrist injury on \_\_\_\_\_. The Claimant did not sustain a compensable depression injury on \_\_\_\_\_." According to the HCFA's the doctor is treating "epicondylitis, shoulder impingement, strain/sprain, and a ganglion cyst." These body parts are compensable. The respondent has initiated no further appeal. These services will be reviewed in accordance with the Medical Fee Guidelines 134.1(c). **Recommend reimbursement of \$196.30.**

CPT Code 99213 on 9-22-03 and 10-10-03 was denied with an "E" – entitlement to benefits. The BRC of 3-12-04 concluded "The Claimant sustained a compensable, right shoulder, right elbow, and right wrist injury on \_\_\_\_\_. The Claimant did not sustain a compensable depression injury on \_\_\_\_\_." According to the HCFA's the doctor is treating "epicondylitis, shoulder impingement, strain/sprain, and a ganglion cyst." These body parts are compensable. The respondent has initiated no further appeal. These services will be reviewed in accordance with the Medical Fee Guidelines 134.1(c). **Recommend reimbursement of \$118.00.**

CPT Code 99212 on 10-2-03 was denied with an "E" – entitlement to benefits. The BRC of 3-12-04 concluded "The Claimant sustained a compensable, right shoulder, right elbow, and right wrist injury on \_\_\_\_\_. The Claimant did not sustain a compensable depression injury on \_\_\_\_\_." According to the HCFA's the doctor is treating "epicondylitis, shoulder impingement, strain/sprain, and a ganglion cyst." These body parts are compensable. The respondent has initiated no further appeal. These services will be reviewed in accordance with the Medical Fee Guidelines 134.1(c). **Recommend reimbursement of \$41.91.**

The carrier denied CPT Code 99080-73 on 8-25-03, 9-5-03, 9-22-03 and 10-2-03. However, the TWCC-73 is a required report. Copies were also made and sent to the insurance carrier. The Medical Review Division has jurisdiction in this matter and, therefore, recommends reimbursement. Requester submitted relevant information to support delivery of service. Per 134.1(c) **recommend reimbursement of \$90.00.**

CPT codes L3700 and L3908 on 9-22-03 denied with an “E” – entitlement to benefits. These are DOP codes. Per Rule 133.307(g)(3)(D) regarding these codes the Requestor is required to discuss, demonstrate and justify that the payment being sought is a fair and reasonable rate of reimbursement. The Requestor has provided sample no EOBs or rationale as evidence that the fees billed are for similar treatment of injured individuals and that reflect the fee charged to and paid by other carriers. **Recommend no reimbursement.**

CPT Code G0283 on 10-10-03 was denied with an “E” – entitlement to benefits. The BRC of 3-12-04 concluded “The Claimant sustained a compensable, right shoulder, right elbow, and right wrist injury on \_\_\_\_\_. The Claimant did not sustain a compensable depression injury on \_\_\_\_\_.” According to the HCFA’s the doctor is treating “epicondylitis, shoulder impingement, strain/sprain, and a ganglion cyst.” These body parts are compensable. The respondent has initiated no further appeal. These services will be reviewed in accordance with the Medical Fee Guidelines 134.1(c). **Recommend reimbursement of \$14.91**

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees from 8-25-03 through 10-10-03 as outlined above:

- 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.

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 29<sup>th</sup> day of October, 2004.

Donna Auby  
Medical Dispute Resolution Officer  
Medical Review Division

## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** October 6, 2004

**RE:**

**MDR Tracking #:** M5-04-4127-01

**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:**

- Treatment notes from \_\_\_\_\_
- TWCC 73 forms, TWCC 53 form
- CCH Hearing results
- Daily treatment notes from \_\_\_\_\_
- Progress notes from \_\_\_\_\_
- Treatment notes from \_\_\_\_\_
- Treatment notes from \_\_\_\_\_

**Submitted by Respondent:**

- Statement letter from the case manager
- Treatment notes from \_\_\_\_\_
- TWCC 73 forms
- Daily notes from \_\_\_\_\_

**Clinical History**

According to the supplied documentation it appears the claimant sustained an injury on \_\_\_ when she abruptly turned while at work and struck her right shoulder, elbow and wrist on a fence. The claimant was seen the following day at \_\_\_\_\_ where she was diagnosed with a wrist sprain. Plain film x-rays were performed and were negative. The claimant was given medication and released. The claimant was seen on 6/3/03 by \_\_\_\_\_ who reported the claimant should continue with medications as well as begin working on range of motion, strengthening and therapy. The claimant was referred to and treated by \_\_\_\_\_, who performed 11 physical therapy sessions. On 7/30/03 the claimant

requested to change treating doctors to \_\_\_\_\_ and it was approved. On 8/25/03 \_\_\_\_\_ diagnosed the claimant with right lateral epicondylitis and a possibility of compression of the radial nerve as well as a right wrist sprain. The claimant began active and passive therapies on her right upper extremity. The claimant was also seen by \_\_\_\_\_ in addition to her chiropractic therapy program. The documentation continues beyond the date of service in question.

### **Requested Service(s)**

Office visits, (97140) manual therapy technique, (97035) ultrasound, (G0283) electrical stimulation unattended, (97018) paraffin bath, (97110) therapeutic procedures for dates of service 9-22-03 through 11-17-03.

### **Decision**

I agree with the insurance carrier and disagree with the treating doctor that the services rendered between 9/22/03 through 11/17/03 were not medically necessary.

### **Rationale/Basis for Decision**

According to the supplied documentation it appears the claimant sustained an injury on \_\_\_\_\_. The documentation supports a right shoulder, elbow and wrist sprain/strain. The initial documentation from the Emergency room as well as from \_\_\_\_\_ reveal that the claimant's injuries were limited to those stated above. Although future diagnoses by \_\_\_\_\_ were more expansive, they were not supported by objective documentation. According to the Official Disability Guidelines, (pages 1129 -1130) physical therapy guidelines allow for a fading treatment frequency from up to 3 visits per week to 1 or less for a total of 9 visits over 8 weeks. The Chiropractic Guidelines allow for this same amount. Documentation supplied from \_\_\_\_\_ reveals the claimant was treated 11 visits and was directed on a home based exercise program. The Official Disability Guidelines for a sprain/strain of the wrist and hands also allow for 9 visits over 8 weeks. The supplied documentation revealed the claimant had an adequate amount of therapy under the care of \_\_\_\_\_ and \_\_\_\_\_. The claimant was not seen for approximately 6 weeks prior to the presentation to \_\_\_\_\_. Without further objective documentation supporting a more involved diagnosis care that began on or after 8/25/03 is not considered reasonable or medically necessary according to the Official Disability Guidelines. No objective documentation was supplied that would reveal that this claimant sustained an injury anything greater than a sprain/strain to her right shoulder, right elbow and right wrist. The only therapy that is considered reasonable or necessary to begin on 8/25/03 was a home based exercise program that had been initiated approximately 2 months prior to the date in dispute.