

MDR Tracking Number: M5-04-4284-01

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 8-18-04.

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 \$650** 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 therapeutic exercises, neuromuscular re-education, manual therapy techniques, therapeutic activities, and range of motion measurements that were denied with "U" and rendered from 2/06/04 through 5/26/04 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 September 15, 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 97530** for dates of service 3/22/04, 3/24/04, 3/26/04, 4/26/04, 4/28/04, and 4/30/04 was denied by the carrier with "F", fee guideline reduction. However, no payment was made. The respondent raised no other reasons for denying reimbursement for this service. **Reimbursement is recommended in the amount of \$207.90.**

**CPT code 97110** for dates of service 3/26/04, 4/28/04, and 4/30/04: 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 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 2/06/04 through 5/26/04 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 10<sup>th</sup> day of November 2004.

Regina L. Cleave  
Medical Dispute Resolution Officer  
Medical Review Division

RLC/rlc

Enclosure: IRO decision

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**NOTICE OF INDEPENDENT REVIEW DECISION**

November 8, 2004

**Re: IRO Case # M5-04-4284**

Texas Worker's Compensation Commission:

Envoy Medical Systems, LP (Envoy) has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule 133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to Envoy for an independent review. Envoy has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, Envoy

received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Orthopedic Surgery, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting 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 referral to Envoy for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the Envoy reviewer who reviewed this case, based on the medical records provided, is as follows:

#### **Medical Information Reviewed**

1. Table of disputed service 4/21/03 – 5/20/03
2. Explanation of benefits
3. Letter from orthopedic surgeon
4. Orthopedic surgeon office notes
5. Letter from therapy provider 9/17/04 with prescription and multiple physical therapy notes

#### History

The patient injured her right shoulder in \_\_\_\_\_. The patient had a sprain at the AC joint and a complete rotator cuff tear. She underwent surgery on 2/11/04, including open repair of a very large traumatic rotator cuff tear. Her post operative course was complicated by the development of significant weakness and the development of adhesive capsulitis. The patient was given multiple follow-up treatments including subacromial steroid injections and extensive physical therapy. For some reason numerous physical therapy techniques were denied as medically unnecessary.

#### Requested Service(s)

Therapeutic exercises, neuromuscular reeducation, manual therapy techniques, therapeutic activities, range of motion measurements 2/6/04 – 5/26/04

#### Decision

I disagree with the carrier's decision to deny the requested services.

#### Rationale

All of the disputed services appeared from the medical records provided for this review to be medically necessary and appropriate for this patient's care. The patient's condition was very complicated and did not follow the usual parameters for rotator cuff repair. The complicated course included a very large, extensive rotator cuff tear and post operative complications, including adhesive capsulitis. There is no evidence in the records of abuse of the system.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

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Daniel Y. Chin, for GP