

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, 133.307 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 08-18-04.

The IRO reviewed manual therapy, therapeutic exercises, electrical stimulation, therapeutic activities, ultrasound with range of motion measurements rendered from 01-12-04 through 02-18-04 that were denied based upon "V".

The IRO determined that manual therapy, therapeutic exercises, therapeutic activities and ultrasound **were** medically necessary. The electrical stimulation and range of motion measurements were determined by the IRO to **not** be medically necessary.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the **majority** of 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 \$650.00** 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.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The respondent raised no other reasons for denying the above listed services.

This Findings and Decision is hereby issued this 12th day of October 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby **ORDERS** the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 01-12-04 through 02-18-04 in this dispute.

This Order is hereby issued this 12th day of October 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dlh
Enclosure: IRO Decision

September 28, 2004

REGINA CLEAVE
~~TEXAS WORKERS COMP. COMISSION~~
AUSTIN, TX 78744-1609

CLAIMANT:
EMPLOYEE:
POLICY: M5-04-4288-01
CLIENT TRACKING NUMBER: M5-04-4288-01

Medical Review Institute of America (MRIOA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Workers Compensation Commission has assigned the above-mentioned case to MRIOA for independent review in accordance with TWCC Rule 133 which provides for medical dispute resolution by an IRO.

MRIOA has performed an independent review of the case in question to determine if the adverse determination was appropriate. In performing this review all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the TWCC approved doctor list (ADL). The reviewer has signed a statement indicating they have no known conflicts of interest existing between themselves and the treating doctors/providers for the patient in question or any of the doctors/providers who reviewed the case prior to the referral to MRIOA for independent review.

Records Received:

Records received from the State:

- Notification of IRO assignment, dated 09/15/04 - 1 page
- Texas Worker's Compensation Commission request for Medical Dispute Resolution, dated 09/15/04 - 1 page
- Medical Dispute Resolution Request/Response, undated - 2 pages
- Table of Disputed Services, dated 01/12/04-02/18/04 7 pages
- Liberty Mutual Explanation of Payments - 10 pages

Records Received from Work & Rehab:

- Letter from Bubba Klostermann, OT, CVE, CEAS, dated 09/17/04 – 1 page
- Letter from Tina Loza, PT, dated 03/04/04 – 1 page
- Discharge Summary, undated – 1 page
- Chart Notes, dated 03/04/04 – 1 page
- Staffing Reports, dated 02/17/04–02/24/04 – 2 pages
- Letter from Tina Loza, PT, dated 02/12/04 – 1 page
- Staffing Reports, dated 01/20/04–02/03/04 – 3 pages
- Shoulder Re-Evaluation, dated 01/08/04 – 1 page
- Letter from Tina Loza, PT, dated 01/07/04 – 1 page
- Letter from Tina Loza, PT, dated 12/17/03 – 1 page
- Adhesive Capsulitis Activity Flow Sheet, dated 01/23/04–03/04/04 – 3 pages
- Shoulder Activity Flow Sheet, dated 01/02/04–01/21/04 – 2 pages
- Prescription, dated 02/12/04 – 1 page
- Prescription, dated 01/26/04 – 1 page
- Prescription, dated 01/14/04 – 1 page
- Prescription, dated 01/12/04 – 1 page
- Daily Charge Tickets, dated 01/12/04–02/18/04 – 22 pages

Records Received from Dr. Vaughan:

- Fax Cover Sheet, dated 09/16/04
- Letter from Medical Review Institute to Dr. Vaughan, dated 09/10/04 – 1 page
- Letter from Dr. Vaughan, dated 09/08/03 – 3 pages
- Electromyography Laboratory Report, dated 09/08/03 – 1 page

Summary of Treatment/Case History:

This patient had a reported work-related shoulder injury on _____. He went on to require a rotator cuff and AC joint repair. He was evaluated and treated post-operatively in PT beginning 10/01/03. Due to complications of adhesive capsulitis, the patient underwent a second shoulder involving arthroscopic excision, along with closed manipulation on 01/09/04.

The patient was prescribed post-operative PT beginning 01/12/04 on a five-time per week basis for three weeks. Subsequent prescriptions reduced the utilization to three times per week. The PT progress notes indicate the patient had limited shoulder range of motion (ROM), strength, and function after the surgery of 01/09/04.

During the treatments in the dates of question, the patient received manual therapy, ultrasound, electrical stimulation (01/16/04 only), therapeutic exercise, and therapeutic activities.

The patient continued post-operative PT through 02/18/04, the date last seen. At that point he was functioning at a level consistent with the physical demands of his job. Also, he showed a clinically successful outcome with ROM as follows: 160 flexion, 165 abduction, and 70 external rotation.

Questions for Review:

1. Please advise medical necessity of manual therapy technique (#97140), therapeutic exercises (#97110) electrical stimulation (#G0283) therapeutic activities (#97530), ultrasound (#97035) with range of motion measurements (#95851). Denied by carrier for medical necessity with "V" Codes.

Explanation of Findings:

The treatment notes show an appropriate progression in PT from 01/12/04 through 02/18/04. Patients undergoing arthroscopic excision and closed manipulation are appropriately treated on a daily basis for up to three weeks afterward. The visits then generally reduce to three times per week, as occurred in this case. Because of the complexity of the patient's condition, involving two shoulder surgeries and complications of adhesive capsulitis, the timeframe and volume of treatment over the course of care appears supported.

Ultrasound treatments (#97035) used early in the post-operative course were appropriate for pain control and to aid in heating the shoulder joint capsule for optimal stretching.

Patients who are post-operative for complications of adhesive capsulitis require manual therapy treatments (#97140). The focus of these treatments is to stretch the joint capsule and surrounding tissue in order to maximize ROM. The flow charts show a typical timeframe of 30 minutes of application of #97140. This is a reasonable amount of time given the clinical findings of adhesive capsulitis.

The treatment notes demonstrate an appropriate progression of exercise (#97110). Up to 30 minutes per session would be deemed reasonable. Therapeutic activities (#97530) were appropriately used and documented and involved one-on-one dynamic activities to improve functional performance. Again, up to 30 minutes per session would be deemed reasonable.

Most of the codes that are charged are accounted for in the treatment and/or flow charts. The exception is code #G0283 (electrical stimulation), which is not accounted for in the documentation. Also, the use of code #95851 (ROM measurements) is not warranted, seeing that the ROM measures on 02/12/04 were unilateral and not comparative in nature.

The successful outcome experienced by this patient attest to the medical necessity of the treatment choices and the utilization of PT. The final discharge note of 03/04/04 indicates the patient was able to return to full duty work without restrictions or complications.

Electrical stimulation, code #G0283, was charged on 01/16/04. However, the treatment note contains no information about the set up or application of this service. It cannot, therefore, be certified.

The use of code #95851 is not supported as charged on 02/12/04. The PT simply jotted down ROM measures at the conclusion of care. The use of this code should include bilateral and comparative measures. Simply jotting down the patient's final ROM does not support the use of this code on 02/12/04.

Conclusion:

Question 1: Please advise medical necessity of manual therapy technique (#97140), therapeutic exercises (#97110) electrical stimulation (#G0283) therapeutic activities (#97530), ultrasound (#97035) with range of motion measurements (#95851). Denied by carrier for medical necessity with "V" Codes.

Decision to Certify:

#97140 – Manual therapy techniques: The diagnosis, symptoms, and documentation support the use of this code over the post-operative course of care. Up to 30 minutes per session would be deemed reasonable.

#97110 – Therapeutic exercise: The documentation shows appropriate progression of exercise and the use of this code. Patients experiencing an increase in shoulder ROM require an exercise format as used in this case to maximize functional ROM. Up to 30 minutes per session would be deemed reasonable.

#97530 – The progression of dynamic, functional activity supports the use of this code. Up to 30 minutes per session would be deemed reasonable.

#97035 – Ultrasound treatments would be expected, given the diagnosis of post-operative adhesive capsulitis. This code is appropriately used for applications of ultrasound as occurred in this case. Treatment times usually involve 7-minute applications to a specific area. Even though the code allots 15 minutes, this includes set up time. Thus, the use of this code as documented is justified.

Decision to Not Certify:

#G0283 – This code is a HCPCS code that is equivalent to #97140 (unattended electrical stimulation). The application of electrical stimulation is not justified, seeing that it was only charged once (on 01/16/04), and the treatment note does not contain information about the location or setup of electrical stimulation.

#95851 – This code, which applies to range of motion measures, was charged on 02/12/04. It is supposed to include a report. The information supplied does not contain a separate reporting mechanism to justify the use of this code. Simply jotting down a person's range of motion within a treatment note or progress note does not constitute appropriate use of this charge.

References Used in Support of Decision:

1. Pattern D: Impaired Joint Mobility, Motor Function, Muscle Performance, and Range of Motion Associated with Connective Tissue Dysfunction. In *Guide to Physical Therapist Practice*. 2nd Edition. American Physical Therapy Association. Alexandria, VA. 2001. Pp. 205 – 222.
2. Pattern I: Impaired Joint Mobility, Motor Function, Muscle Performance, and Range of Motion Associated with Bony or Soft Tissue Surgery. In *Guide to Physical Therapist Practice*. 2nd Edition. American Physical Therapy Association. Alexandria, VA. 2001. Pp. 277 –294.
3. *Current Procedural Terminology: 2001*. 2nd Edition. American Medical Association.

This reviewer has a Masters in Physical Therapy. They are currently the Clinic Manager of an orthopedic physical therapy practice. The reviewer has been certified by the American Board of Physical Therapy Examiners as an Orthopedic specialist. The reviewer is also a certified manual physical therapist. The reviewer has been certified by the National Strength and Conditioning Association as a Sports and Conditioning Specialist. The reviewer is a member of the American Physical Therapy Association. The reviewer is the author of 64 patient education modules in a series entitled A Patient's Guide to Rehabilitation. The reviewer has been in active practice since 1991.

MRIOA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the treating provider, payor and/or URA, patient and the TWCC.

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The written opinions provided by MRIOA represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to MRIOA for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Medical Review Institute of America assumes no liability for the opinions of its contracted physicians and/or clinician advisors. The health plan, organization or other party authorizing this case review agrees to hold MRIOA harmless for any and all claims, which may arise as a result of this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

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