

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 (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 August 30, 2004.

The IRO reviewed the water circulating heat/cold pad (E0237), neuromuscular stimulator (E0745), and office visits (99213) from 09/19/03 through 10/28/03 that were denied based upon "U".

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.

The water circulating heat/cold pad (E0237), neuromuscular stimulator (E0745), and office visits (99213) from 09/19/03 through 10/03/03 **were** found to be medically necessary. The water circulating heat/cold pad (E0237), neuromuscular stimulator (E0745), and office visits (99213) from 10/08/03 through 10/28/03 **were not** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for water circulating heat/cold pad (E0237), neuromuscular stimulator (E0745), and office visits (99213).

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.

On September 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.

- **HCPCS Code A4556 for dates of service 10/14/03 and 04/27/04 denied as "G – global". Per Rule 133.304 (c) Carrier didn't specify which service this was global to, therefore it will be reviewed according to Rule 134.202(c)(2) and the 2003 and 2004 DMEPOS Fee Schedule, reimbursement in the amount of \$30.36 ($\$12.14 \times 125\% = \15.18) is 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 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 Order is applicable to dates of service 09/19/03 through 04/27/04 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 Order is hereby issued this 9th day of October 2004

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf

Enclosure: IRO decision

NOTICE OF INDEPENDENT REVIEW DECISION

Date: October 6, 2004

RE:

MDR Tracking #: M5-05-0007-01

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:

- Correspondence Letter dated 9/24/04 from ___
- Initial Evaluation Report dated 9/19/03 from ___
- Follow-up Office Note dates 10/13/03, 1/6/04, 2/6/04, 4/27/04 from ___
- Correspondence Letter dated 11/13/03 from ___
- Employers First Report of Injury dated 9/9/03
- TWCC 73 9/19/03, 10/13/03, 11/13/03, 1/6/04, 2/6/04, 4/27/04, 4/30/04
- Prescription for Durable Medical Equipment dates 9/19/03, 10/14/03, 4/27/04
- Daily Treatment Log dates 9/22/03-12/1/03 from ___
- Initial Evaluation dated 9/30/03 from ___
- Upper Extremity Evaluation dates 10/22/03, 11/10/03 and 3/24/04 from ___

- TWCC 73 dated 10/22/03 from _____
- Pre-Authorization Determination dated 12/17/03
- TWCC 69 Report dated 4/30/04 from _____
- Physical Performance Examination dated 1/8/04
- _____ Initial Evaluation 11/17/03
- Daily Treatment Log for Active Rehabilitation dates 11/17/03-12/18/03
- MRI of the right shoulder dated 10/3/03 from _____
- Radiographic report of the AC joint dated 9/23/03 from _____

Submitted by Respondent:

- Table of Disputed Services dates 9/19/03-10/28/03
- Explanation of Review dates 9/19/03-10/28/03 from _____
- Health Insurance Claim Form dates 9/19/03-4/27/04 from _____

Clinical History

I have had the opportunity to review the medical records in the above mentioned case for the purpose of an Independent Review. The claimant injured his right shoulder ___ while working for _____. The claimant initially sought care at ___ Initial on 9/19/03 with _____, who diagnosed the claimant with a rotator cuff tear of the supraspinatus tendon with acromioclavicular joint sprain/strain. The claimant's treatment has consisted of passive physiotherapy modalities, soft tissue mobilization of the cervical spine and right shoulder. The claimant was referred to ___ for evaluation and prescription medication. The claimant had a MRI of the right shoulder performed on 10/3/03 at ___, which revealed tendinosis of the tendon of the supraspinatus. Radiographs of the bilateral AC Joint were exposed on 9/23/03, which were normal. The claimant was referred to ___ for evaluation and performed steroid injection which provided relief to the right shoulder complaint. The claimant participated in active rehabilitation at _____ and was determined at maximum medical improvement on 4/30/04 with a 6% whole person impairment from _____.

Requested Service(s)

Water Circulating Heat/Cold Pad (E0237), Neuromuscular Stimulator (E0745) and Office Visits (99213) for dates of service 9/19/03-10/28/03.

Decision

I disagree with the insurance carrier and find that water circulating heat/cold pad (E0237), neuromuscular stimulator (E0745) and office visits (99213) are reasonable and necessary for the claimant for a period of 10 chiropractic treatments over a 5 week period.

I agree with the insurance carrier and find that water circulating heat/cold pad (E0237), neuromuscular stimulator (E0745) and or supplies are not reasonable and necessary after 10/3/03 and further treatment beyond this time frame could be consider excessive.

Rationale/Basis for Decision

I disagree with the insurance carrier and find that water circulating heat/cold pad (E0237), neuromuscular stimulator (E0745) and office visits (99213) are reasonable and necessary for the claimant for a period of 10 chiropractic treatments over a 5 week period. I form my decision using the Official Disability Guidelines 8th Edition which allows a total of up to 10 chiropractic treatments/ physical therapy treatments over a 5 week period with evidence of functional improvement, the doctor should help avoid chronicity and gradually fade the claimant into active self-directed care. Based on this information it would seem medically reasonable and necessary for the claimant to have the disputed treatments and durable medical equipment for no longer than 5 weeks or 10/3/03. The claimant was co-managed with ____, orthopedic surgeon, and follow-up office visits at ____ would seem reasonable to monitor the claimant progress with treatment outside his office until the claimant reaches maximum medical improvement.

I agree with the insurance carrier and find that water circulating heat/cold pad (E0237), neuromuscular stimulator (E0745) and or supplies are not reasonable and necessary after 10/3/03 and further treatment beyond this time frame could be consider excessive. I form this decision using the Official Disability Guidelines 8th Edition which allows up to 10 chiropractic treatment/physical therapy treatment over a 5 weeks for rotator cuff syndrome. The Official Disability Guideline 8th Edition is a guideline of specific conditions which uses a major source being the “Mercy Guidelines”, the consensus document created by the American Chiropractic Association in conjunction with the Congress of State Chiropractic Associations, entitled Guidelines for Chiropractic Quality Assurance and Practice Parameters, Proceedings of the Mercy Center Consensus Conference. It from these Guidelines I form my decision for the above reference claimant.