

MDR Tracking Number: M5-05-0016-01

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, 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 August 30, 2004.

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 CPT Code 97140-GP for date of service 09/26/03 and CPT Codes 99213, 97140-GP, and G0283 were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

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 17, 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 19 days of the requestor's receipt of the Notice.

- CPT Code 99213 for dates of service 09/03/03 through 09/19/03 and 09/26/03 denied as "N72, N75, or N11 – Not appropriately documented." In accordance with Rule 133.307 (g)(3)(A-F), the requestor did not submit relevant information to support delivery of service; therefore, reimbursement is not recommended.
- CPT Code 97140-GP for dates of service 09/03/03 through 09/05/03 and 11/14/03 denied as "N72 or N75 – Not appropriately documented." In accordance with Rule 133.307 (g)(3)(A-F), the requestor did not submit relevant information to support delivery of service; therefore, reimbursement is not recommended.
- CPT Code G0283 for dates of service 09/03/03 and 09/04/03. EOBs were not submitted by either party. Per Rule 133.307(e)(2)(A) the requestor did not submit HCFAs for this CPT code; therefore, reimbursement is not recommended.
- CPT Code G0283 for dates of service 09/26/03 and 11/14/03 denied as "N75, N7 – Not appropriately documented." In accordance with Rule
- 133.307 (g)(3)(A-F), the requestor did not submit relevant information to support delivery of service; therefore, reimbursement is not recommended

Based upon the review of the disputed healthcare services within this request, the Medical Review Division has determined that the requestor is not entitled to reimbursement.

This Decision is hereby issued this 7th day of January 2005.

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf

Enclosure: IRO Decision

October 14, 2004

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-05-0016-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: 5055

Dear:

IRI has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc. and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in chiropractic medicine and is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor:

- consultation and office note 06/24/03
- treatment logs 06/26/03 – 02/27/04
- treatment notes 03/30/04 & 09/22/03
- radiology report 03/10/03

Information provided by Respondent:

- designated doctor exam 03/30/04

Clinical History:

The claimant was injured in a work-related accident that occurred on _____. He noted pain over the right shoulder and continued working.

The claimant was initially managed by an M.D. The claimant had a course of physical therapy applications from 04/13/98 through 06/12/98. The worker had an additional course of physical therapy applications from 09/15/98 through 10/21/98. MR imaging of the right shoulder performed on 03/10/03 revealed impingement syndrome of the right shoulder with hypertrophic changes involving the right acromial clavicular joint. Designated doctor evaluation on 03/17/03 revealed that the claimant was not at MMI and was diagnosed with an impingement over the right shoulder.

The worker presented to the offices of a different D.C. on 06/24/03 following a Texas Worker's Compensation Commission (TWCC) approved TWCC-53 (change of treating doctor form). The claimant presented to the offices of an orthopedic surgeon on 09/22/03 and was assessed with a right shoulder rotator cuff tendinosis and impingement syndrome over the right shoulder; cortisone and lidocaine injection were administered. A designated doctor evaluation on 03/03/04 revealed that the claimant had an 11% whole person impairment of function and was placed at maximum medical improvement.

Disputed Services:

Manual therapy, office visits, electrical stimulation-unattended (one or more areas other than wound care) during the period of 09/26/03 – 10/09/03.

Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were not medically necessary in this case.

Rationale:

The provider has not submitted sufficient medical data that would warrant the application of manual therapy, office visits, or electrical stimulation with some 3 months following his initial evaluation performed on 06/24/03. There is no qualitative/quantitative medical data to establish efficacy for the continued passivity in therapeutic management that is noted in the dates of service 09/26/03 through 10/09/03.

The aforementioned information has been taken from the following guidelines of clinical practice and/or peer reviewed references.

- ACOM Occupational Medicine Practice Guidelines, Chapter 8. *Neck and Upper Back Complaints*. Page 172-175.
- *Overview of Implementation of Outcome Assessment Case Management In The Clinical Practice*. Washington State Chiropractic Association; 2001, 54p.
- *Shoulder*. Work Loss Data Institute; 2003. 15p.
- Trionovich, S. J. et al. *Structural Rehabilitation Of The Spine And Posture: Rationale For Treatment Beyond Resolution Of Symptoms*. J Manipulative Physiol Ther. 1998 Jan;21(1):37-50.