

MDR Tracking Numbers: M5-05-0106-01

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 9-03-04.

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 the office visits, therapeutic exercises, manual therapy, and neuromuscular re-education services rendered from 12/17/03 through 1/31/04 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 fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, the request for reimbursement for dates of service 12/17/03 through 1/31/04 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Findings and Decision is hereby issued this 10th day of November 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division

RLC/rlc

Date: November 5, 2004

RE:

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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:

- Letter from provider
- Table of services
- Extensive summary of case history
- Employer's E1 Report
- Notes from _____
- Notes from _____
- FCE reports
- X-Ray reports
- MRI reports
- Exercise documentation

Submitted by Respondent:

- Chronic Pain Management notes
- Employer's E1 report
- MRI report
- _____ Notes
- Daily notes from _____
- TWCC forms

Clinical History

According to the supplied documentation, it appears the claimant sustained an injury when she tripped across a hose and fell on her shoulder while at work on _____. The claimant went to _____ for treatment. The claimant then was sent to an orthopedic specialist for evaluation. _____ gave the claimant a steroid injection and prescribed therapy. After therapy failed, the claimant underwent surgery on 05/30/2003 to her left shoulder that included extensive arthroscopic glenohumeral joint debridement as well as a rotator cuff tear repair. Another physical therapy program was implemented. On 09/16/2003, the claimant changed treating doctors to _____. Physical therapy began at _____. Passive and active therapies continued from 09/16/2003 until past the dates of service in question.

Requested Service(s)

Please review and address the medical necessity of the 99212 - office visits, 97110 - therapeutic exercises, 97140 - manual therapy, and 97112 - neuromuscular re-education dated 12/17/2003 – 01/31/2004.

Decision

I agree with the insurance company that the services were not medically necessary.

Rationale/Basis for Decision

According to the supplied documentation, it appears that the claimant underwent surgery on 05/30/2003. After her treating surgeon released her to therapy, an 8-12 week protocol of physical/chiropractic therapy protocol would be reasonable and medically necessary. Without objective improvement, continued ongoing therapy that was rendered in this case is not seen as reasonable or medically necessary. The daily notes reviewed are almost identical each day those services were rendered. The therapy was not objectively supported by the documentation supplied. The claimant began therapy on 09/16/2003 at 3 times a week. On 12/17/2003, the first date in dispute, the claimant was still being seen 3 times a week without any objective improvement. Continued therapy that was not improving the claimant's condition is not seen as medically warranted. The therapy continued on a 3 time a week schedule with no objective improvement being documented. Current medical/chiropractic protocols require improving the claimant's symptoms while reducing the frequency of care. The therapy in question begins approximately 6 months post-surgery. At this time, other treatment options would be necessary to prevent possible doctor-induced dependence. The documentation did not report any home based treatments which are also necessary in this type of injury. As stated above, without objective, documented improvement, ongoing care is not considered appropriate in this case.