

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 9-20-04.

The Medical Review Division has reviewed the IRO decision and determined that the requestor did not prevail on the majority of the medical necessity issues. The IRO determined that the therapeutic procedures (97110) were found to be medically necessary. The IRO agreed with the previous determination that the office visits, manual therapy techniques, electrodes (pair), replacement batteries for TENS unit, neuromuscular stimulator, and neuromuscular re-education were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee. The respondent raised no other reasons for denying reimbursement for the above listed services.

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 above Findings and Decision is hereby issued this 28<sup>th</sup> day of December 2004.

Dee Z. Torres  
Medical Dispute Resolution Officer  
Medical Review Division

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 on or 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 3-3-04 through 5-27-04 as outlined above 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 28th day of December 2004.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

Enclosure: IRO Decision

## NOTICE OF INDEPENDENT REVIEW DECISION

December 1, 2004

Program Administrator  
Medical Review Division  
Texas Workers Compensation Commission  
7551 Metro Center Drive, Suite 100, MS 48  
Austin, TX 78744-1609

RE: Injured Worker:  
MDR Tracking #: M5-05-0287-01  
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) 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 TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered 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 matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. TMF's health care professional 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 TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

### Clinical History

This 46 year-old female injured her right shoulder on \_\_\_\_ while moving heavy boxes. Her diagnosis is torn rotator cuff. She has been treated with medications, therapy and surgery.

### Requested Service(s)

99213-Office visit, 97110-Therapeutic procedure, 97140-Manual therapy techniques, A4556-Electrodes (pair), A4630-Replacement batteries for Transcutaneous Electrical Neural Stimulation (TENS) Unit, E0745-Neuromuscular stimulator, 97112-Neuromuscular re-education for dates of service 03/03/04 through 05/27/04

### Decision

It is determined that there is medical necessity for the therapeutic procedure to treat this patient's medical condition for dates of service 03/03/04 through 05/27/04. However, there is no medical necessity for the office visit, manual therapy techniques, electrodes (pair), replacement batteries for TENS Unit, neuromuscular stimulator, and neuromuscular re-education for dates of service 03/03/04 through 05/27/04 to treat this patient's medical condition.

### Rationale/Basis for Decision

Expectation of improvement in a patient's condition should be established based on success of treatment. Continued treatment is expected to improve the patient's condition and initiate restoration of function. In this case, there is adequate documentation of objective and functional improvement in this patient's condition. Specifically, the patient's right shoulder ranges of motion significantly increased therefore, the therapeutic exercises were medically necessary to treat this patient's medical condition for dates of service 03/03/04 through 05/27/04.

However, the medical records failed to document the medical necessity for the other procedures and treatments. Specifically, in regard to the office visits, there is no support for the medical necessity for this high level of service. In regards to the TENS treatment, the efficacy of TENS remains unproven therefore, the replacement batteries for the unit are not medically necessary. The neuromuscular reeducation, neuromuscular stimulator and electrodes (pair) are not medically necessary as there was no medical documentation stating this patient had any type of neuropathology that would necessitate the application of this service. And finally, the medical record documentation does not indicate what type of manual therapy techniques were used for the patient, therefore the manual therapy techniques are not medically necessary to treat this patient's medical condition for dates of service 03/03/04 through 05/27/04.

Sincerely,

Gordon B. Strom, Jr., MD  
Director of Medical Assessment

GBS:dm  
Attachment

## Information Submitted to TMF for TWCC Review

**Patient Name:**

**TWCC ID #: M5-05-0287-01**

### **Information Submitted by Requestor:**

- Request for Reconsideration
- Daily Notes
- Impairment Rating
- Diagnostic Tests
- Required Medical Evaluation
- Occupational Therapy Notes
- Work Hardening Program
- Procedure Notes
- Impairment Rating

### **Information Submitted by Respondent:**

- Progress Notes
- Dr Emauel Progress Notes
- Required Medical Evaluation
- Diagnostic Tests
- Procedure Notes
- Impairment Rating
- Orthopedic Progress Notes
- Occupational Therapy Notes
- Work Hardening Program
- Consult
- Claims