

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. This dispute was received on 1-31-05.

In accordance with Rule 133.308 (e)(1), requests for medical dispute resolution are considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute. The following date(s) of service are not timely and are not eligible for this review: 12-29-03 - 1-30-04.

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, neuromuscular re-education, manual therapy technique, group therapy, VR review report by treating doctor, therapeutic exercises, electrical stimulation, gait training and ultrasound were not medically necessary.

Dates of service pertaining to CPT code 97150 (group therapy) and CPT code 99455 (VR review report by treating doctor) were withdrawn by the Requestor in a facsimile dated 4-4-05 and will not be a part of this dispute. The Requestor also withdrew numerous services which had been paid by the Carrier.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were not the only fees involved in the medical dispute to be resolved.

On 3-9-05, 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.

Regarding CPT code 97112 for dates of service 2-20-04, 3-5-04, and 10-05-04: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for EOB's in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of \$110.25 (\$36.75 X 3 DOS).**

Regarding CPT code 99212 for dates of service 2-20-04, 5-4-04 and 10-05-04: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for EOB's in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of \$144.09 (\$48.03 X 3 DOS).**

CPT code 98940 on 5-13-04, 5-14-04 and 5-17-04 was denied by the carrier as "R - Documentation supports treatment only to the shoulder. Spine is not documented." The insurance carrier has no TWCC 21 on file. The diagnosis codes for the HCFAS on these dates of service are: V45.8 - OTHER POSTPROCEDURAL STATUS , 781.3 - LACK OF COORDINATION and 729.1 - UNSPECIFIED MYALGIA AND MYOSITIS. Per these diagnosis codes, the doctor was not treating the spine. **Recommend Reimbursement of \$99.93 (\$33.31 X 3 DOS).**

Regarding CPT code 99211 for dates of service 6-14-04: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for EOB's in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of \$27.04.**

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 totaling \$381.31 from 2-20-04 through 6-14-04 outlined above as follows:

- 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 Decision and Order is hereby issued this 20<sup>th</sup> day of April 2005.

Medical Dispute Resolution Officer  
Medical Review Division

Enclosure: IRO Decision

March 28, 2005

TEXAS WORKERS COMP. COMMISSION  
AUSTIN, TX 78744-1609

CLAIMANT:  
EMPLOYEE:  
POLICY: M5-05-1595-01  
CLIENT TRACKING NUMBER: M5-05-1595-01

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 03/09/05 – 1 page
- Texas Workers' Compensation Commission Form, dated 03/09/05 – 15 pages
- Explanation of Medical Benefits, dated 03/10/04–12/16/04 – 34 pages

### Records Received from Pain and Recovery Clinic:

- List of Exhibits, undated – 2 pages
- Texas Workers' Compensation Commission Form, dated 03/09/05 – 2 pages
- Position Statement from Bose Consulting. LLC, undated – 2 pages
- MRI Report, dated 09/25/02 – 1 page
- Imaging Report, dated 10/10/03 – 4 pages
- Functional Capacity Evaluation, dated 05/04/04 – 9 pages
- Orthopedic Report, dated 03/31/04 – 2 pages
- Orthopedic Report, dated 01/21/04 – 1 page
- Operative Report, dated 01/09/04 – 2 pages
- Orthopedic Report, dated 11/18/03 – 2 pages
- Letter from Dr. Brownhill to TASB, dated 09/01/04 – 8 pages
- Letter from Dr. Brownhill to TASB, dated 10/20/03 – 3 pages
- Orthopedic Report, dated 09/26/03 – 2 pages
- Orthopedic Report, dated 08/27/03 – 3 pages
- Psychodiagnostic Evaluation, dated 04/20/04 – 3 pages
- Post-Surgical Evaluation, dated 01/27/04 – 2 pages
- Initial Medical Report, dated 08/08/03 – 2 pages
- Progress Note, dated 09/28/04 – 3 pages
- Letter from Pain and Recovery Clinic – East, dated 05/04/04 – 2 pages
- Letter from Pain and Recovery Clinic – East, dated 04/23/04 – 2 pages
- Request for Reconsideration, dated 09/10/04 – 2 pages
- Progress Note, dated 03/10/04 – 2 pages
- Progress Note, dated 01/23/04 – 2 pages
- Progress Note, dated 12/01/03 – 2 pages
- Progress Note, dated 10/08/03 – 2 pages
- Letter from Dr. Torres, dated 08/18/03 – 1 page
- Initial Medical Report, dated 07/08/03 – 3 pages
- Physical Medicine and Functional Testing, Weekly Activity Report – Work Conditioning, dated 08/23/04–08/27/04 – 1 page
- Request for Preauthorization, Concurrent Review and Voluntary Certification Per TWCC Adopted Amended Rule 134.600, dated 07/06/04 – 1 page
- Physical Medicine and Functional Testing, Weekly Activity Report – Work Conditioning, dated 05/24/04–08/16/04 – 5 pages
- Daily Progress Notes, dated 12/20/04 – 1 page
- Daily SOAP Notes, dated 12/31/03–11/15/04 – 69 pages

## **Summary of Treatment/Case History:**

\_\_\_ claims she injured her right shoulder while lifting at work on \_\_\_\_. Her initial MRI suggested a rotator cuff tear that was not noted on a follow up MRI or arthrogram. She apparently had several months of

physical therapy before undergoing right shoulder decompression in 2004. She had several more months of post-operative therapy and then rehab/work conditioning in 2004. The records indicate she tested in the light physical demand level after rehab.

### Questions for Review:

Dates of service in question 2/2 – 11/15/04. Items in dispute: #99212/#99213 office visits; #97112 – neuromuscular re-education; #97140 – manual therapy technique; #97150 – group therapy; #99455 – VR review report by treating doctor; #97110 – therapeutic exercises; #97032 – electrical stimulation; #97116 – gait training; #97035 – ultrasound; Denied by carrier for medical necessity with “U” codes.

### Explanation of Findings:

Medicare’s Local Determination Coverage (see [www.trailblazerhealth.com](http://www.trailblazerhealth.com)) was utilized for Physical Medicine and Rehabilitation for Orthopedic and Musculoskeletal Diseases and / or Injury for services from 02/02/04 to 11/15/04. Using the Specific Modality Guidelines:

“#97116: This procedure may be medically necessary for training patients whose walking abilities have been impaired by neurological, muscular, or skeletal abnormalities or trauma.” The use of #97116– gait training is not medically necessary for a shoulder injury.

“#97112: This therapeutic procedure is provided to improve balance, coordination, kinesthetic sense, posture, and proprioception (e.g., proprioceptive neuromuscular facilitation, Feldenkreis, Bobath, BAP’s boards and desensitization techniques). The procedure may be reasonable and medically necessary for impairments that affect the body’s neuromuscular system (e.g., poor static or dynamic sitting/standing balance, loss of gross and fine motor coordination, hypo/hypertonicity.)” Since this injury involves the shoulder, this procedure does not appear to be medically necessary.

“#97140: This procedure may be medically necessary as an adjunct to therapeutic exercises when loss of articular motion and flexibility impedes the therapeutic procedure. Due to the duplication of services represented by the code for manual manipulation, soft tissue mobilization, joint mobilization (#97140), or the codes for osteopathic manipulation (#98925–#98929), separate payment will not be allowed if any of these codes are reported on the same day. It may be medically necessary to perform this procedure prior to therapeutic exercises up to 16 sessions within one month.” Although it does not address Chiropractic manipulation the same rationale for duplication for services exists.

“#97032: Please refer to procedure code #G0283 for clinical guidelines for procedure code #97032.” Therefore the use of #97032 for electrical stimulation is incorrect.

“#97110: Therapeutic exercise is performed with a patient either active, active–assisted, or passive (e.g., treadmill, isokinetic exercise, lumbar stabilization, stretching, strengthening). The exercise may be reasonable and medically necessary for a loss or restriction of joint motion, strength, functional capacity, or mobility that has resulted from a specific disease or injury.” Documentation must show objective loss of joint motion, strength, or mobility (e.g., degrees of motion, strength grades, levels of assistance).

"#97150: Since many group procedures do not require the professional skills of a provider, coverage of this procedure will be determined on an individual case basis. Documentation must be made available to Medicare with each claim. Documentation must identify the specific treatment technique(s) used in the group, how the treatment technique will restore function, the frequency and duration of the particular group setting, and the treatment goal in the individualized (patient specific) plan. The number of persons in the group must also be documented."

"For all PM&R modalities and therapeutic procedures on a given day, it is usually not medically necessary to have more than one treatment session per discipline. Depending on the severity of the patient's condition, the usual treatment session provided in the home or office setting is 30 to 45 minutes. The medical necessity of services for an unusual length of time must be documented as described in the "Documentation Requirements" section of this policy."

**Conclusion/Decision to Not Certify:**

Question 1: Address Medical Necessity of: #99213/#99212– office visits, #97112– neuromuscular reeducation, #97140– manual therapy technique, #97150– group therapy, #99455–VR review report by treating doctor, #97110–therapeutic exercise, #97032– electrical stimulation, #97116– gait training, #97035–ultrasound for service dates of 02/02/04 to 11/15/04.

The use of CPT #99213/#99212 from 02/02/04 to 11/15/04 appears to be a routine practice by the clinic. The enclosed documentation does not support the need for an examination on the dates in question.

The clinical documentation does not support the medical necessity of the services #97035, #97150, or #97140 from 02/02/04 to 03/05/04.

The use of CPT #97116 and #97112 are not medically necessary as per the definitions of the procedures do not relate to a shoulder condition.

The use of CPT #97032 is incorrect. The documentation does not disclose the areas treated and it is therefore it is not medically necessary.

The documentation on 03/30/04 does not support the code #99455–VR.

Services from 05/03/04 to 11/15/04 are not medically necessary. The use of #97035 ultrasound is not medically necessary, as the documentation does not describe why additional sessions are needed beyond medicare guidelines.

**References Used in Support of Decision:**

Medicare's Local Determination Coverage (see [www.trailblazerhealth.com](http://www.trailblazerhealth.com)) for Physical Medicine and Rehabilitation for Orthopedic and Musculoskeletal Diseases and / or Injury.

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This reviewer is a Doctor of Chiropractic and certified in Acupuncture. This reviewer is also a diplomate of the American Chiropractic Neurology Board. This reviewer has been in active practice since 1989. MRloA 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 MRloA 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 MRloA 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 MRloA 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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