MDR Tracking Number: M5-05-1914-01

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 03-10-05.

The IRO reviewed muscle testing, therapeutic exercises, manual therapy technique, ultrasound, occupational therapy re-evaluation and exercise equipment rendered from 03-16-04 through 09-15-04 that were denied based upon "V".

The IRO determined that muscle testing, therapeutic exercises, manual therapy technique, ultrasound, occupational therapy re-evaluation and exercise equipment **were** medically necessary post surgery which occurred on 06-16-04 (dates of service 08-06-04 through 09-15-04 in this dispute). The IRO determined that the muscle testing, therapeutic exercises, manual therapy technique, ultrasound, occupational therapy re-evaluation and exercise equipment after 03-05-04 and prior to surgery on 06-16-04 **were not** medically necessary (dates of service 03-16-04 through 04-19-04 in this dispute). The amount of reimbursement due for the medical necessity issues equals
$2,301.51.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the **majority** of 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.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

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 03-25-05, 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.

CPT code 97140 date of service 03-12-04 denied with denial code "G/U687" (this procedure is mutually exclusive to another procedure on the same date of service. By clinical practice standards, this procedure should not be billed in the same treatment period). Per Rule 133.307(c) and 134.202(a)(4) the carrier did not specify which code 97140 was mutually exclusive to. Reimbursement per Rule 134.202(c)(1) is recommended in the amount of **$31.73 ($25.38 X 125%).**

CPT code 99080-73 date of service 04-19-04 denied with denial code "V" (based on peer review further treatment is not recommended). The TWCC-73 is a required report and is not subject to an IRO review per Rule 129.5. The Medical Review Division has jurisdiction in this matter. Reimbursement is recommended in the amount of **$15.00.** A Compliance and Practices referral will be made as the carrier is in violation of Rule 129.5.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees for 03-12-04, 04-19-04 and 08-06-04 through 09-15-04 totaling **$2,348.24** in accordance with the Medicare program reimbursement methodologies effective 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 Findings and Decision and Order are hereby issued this 20th day of April 2005.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

7600 Chevy Chase, Suite 400
Austin, Texas 78752
Phone: (512) 371-8100
Fax: (800) 580-3123

NOTICE OF INDEPENDENT REVIEW DECISION

Date: April 15, 2005

To The Attention Of: TWCC
7551 Metro Center Drive, Suite 100, MS-48
Austin, TX 78744-16091

RE: Injured Worker:
MDR Tracking #: M5-05-1914-01
IRO Certificate #: 5242

Forté 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 Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté 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 from The Neuromuscular Institute of Texas dated 3/31/05
- Initial Evaluation Report dated 1/12/04 from NIT, Brad Burdin, D.C.
- Follow-up Office Visits Notes from NIT, Brad Burdin, D.C. dates 3/15/04-11/24/04
- TWCC 73 from Brad Burdin, D.C. dates 1/12/04-2/10/05
- Occupational Therapy/Testing Script dates 8/2/04-11/18/04
- TWCC 69 dated 2/10/05 from Brad Burdin, D.C.
- Daily Treatment Log from NIT dates 2/23/04-7/30/04
- NIT Initial Evaluation dated 8/2/04 from Kipp Clayton, OTR
- Daily Treatment Log 8/4/04-8/30/04
- NIT Re-Evaluation dated 9/8/04 from Kipp Clayton, OTR
- Prescription for Durable Medical Equipment dated 9/9/04
- Daily Treatment Log 9/8/04-10/1/04 from Kipp Clayton, OTR
- NIT Discharge Evaluation dated 10/5/04 from Kipp Clayton, OTR
- Treatment Log 8/4/04-10/1/04
- Initial Office Visit dated 2/2/04 from Patrick Wilson, M.D.
- Upper Extremity Evaluation from Patrick Wilson, M.D. dates 3/2/04-11/11/04
- Operative Report dated 6/16/04 from Methodist Specialty and Transplant Hospital
- Prescription Physical Therapy and Rehab from Patrick Wilson, M.D. to NIT
- RME Report dated 3/16/04 from Fred Olin, M.D.
- Computerized Muscle Testing Exam dates 2/13/04, 3/16/04, 4/19/04
- Range of Motion Testing 3/16/04 and 4/19/04
- Functional Capacity Evaluation dates 10/5/04 and 11/22/04
- MRI of the Right Shoulder dated 1/23/04 from San Antonio Imaging, INC
- Radiographic Report of Right Shoulder dated 1/23/04 from San Antonio Imaging, INC
- Pre-Authorization Request dated 10/18/04
- Pre-Authorization Approval from Liberty Mutual
- Time Cards for Work Conditioning
- Daily Notes with Flow Sheet and Work Log for Work Conditioning dates 10/25/04-11/19/04

Submitted by Respondent:

- Notice of IRO
- Preliminary Chiropractic Modality Review dated 7/14/04 from Glenn Marr, D.C.
- Reconsideration 7/27/04 from Thomas Sato, D.C.

Clinical History

Mr. ___ is a 53-year-old male who injured his right shoulder on or about ___ while at work for as a customer service technician. The claimant was initially seen at Neuromuscular Institute of Texas by Brad Burdin, D.C. on 1/12/04, who diagnosed the claimant with a right rotator cuff tear with impingement and recommended the claimant have therapy to consist of ultrasound, interferential with heat and soft tissue mobilization. Dr. Burdin also recommended the claimant have x-rays of the right shoulder and a MRI of the right shoulder with a referral to orthopedic surgeon Patrick Wilson, M.D. The MRI of the right shoulder, which was performed on 1/23/04 at San Antonio Diagnostic Imaging revealed degenerative osteoarthritis of the acromioclavicular joint, tendonitis of the rotator cuff tendon with some fluid layering on top of the rotators cuff tendon and with increased thickness of the rotator cuff tendon. The claimant was evaluated by Patrick Wilson, M.D. on 2/2/04 and diagnosed the claimant with impingement syndrome and recommended the claimant have steroid injections and participate in physical therapy. The claimant participated in physical therapy at NIT and received steroid injections in the right shoulder from Dr. Wilson.
The claimant continued to complain of right shoulder pain with no relief of symptoms in the right shoulder and required surgical intervention, which was performed on 6/16/04 by Patrick Wilson, M.D. The claimant participated in post-surgical rehab at NIT as well as a work-conditioning program, which was completed 11/19/04. The claimant was determined at maximum medical improvement on 2/10/05 with an 11% whole person impairment by his treating doctor, Brad Burdin, D.C.

Requested Service(s)

Muscle Testing (97750), Therapeutic Exercises (97110), Manual Therapy Technique (97140), Ultrasound (97035), Occupational Therapy Re-Evaluation (97004), Exercise Equipment (A9300) for dates of service 3/16/04 to 9/15/04.

Decision

I agree with the insurance carrier and find that Muscle Testing (97750), Therapeutic Exercises (97110), Manual Therapy Technique (97140), Ultrasound (97035), Occupational Therapy Re-Evaluation (97004), Exercise Equipment (A9300) are not reasonable and necessary after 3/5/04 and further treatment beyond this time frame, up to the date of operation on 6/16/04, could be consider excessive due to the lack of progress in the claimants subjective complaints.

I disagree with the insurance carrier and find that Muscle Testing (97750), Therapeutic Exercises (97110), Manual Therapy Technique (97140), Ultrasound (97035), Occupational Therapy Re-Evaluation (97004), Exercise Equipment (A9300) are reasonable and necessary for up to 24 visits over 14 weeks post surgery which occurred on 6/16/04.

Rationale/Basis for Decision

I form this decision using the Official Disability Guidelines 10th Edition which 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.

The Official Disability Guideline 10th Edition allows up to 10 chiropractic/physical-therapy treatment visits with evidence of functional improvement over an 8 week period for an apparent rotator cuff syndrome or shoulder impingement. Due to the claimant's continued subjective complaints and lack of improvement through the initial trial of care with comanagement of orthopedic specialist Patrick Wilson, M.D. surgical intervention was evidently based on MRI findings dated 1/23/04. However, the treatment provided to the claimant post surgery which was performed on 6/16/04 was reasonable and necessary for up to 24 treatment visits over 14 week period. Treatment post surgery would be considered excessive after 9/25/04. It would have seemed reasonable for the claimant after 9/25/04 to have been faded from active care and instructed with a home treatment exercise program of stretching and strengthen of the right shoulder. It is from these Guidelines I form my decision for the above reference claimant.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 15th day of April 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder