

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 03-14-05.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the 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 \$650.00** 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 the only issue** to be resolved. The OT evaluation, therapeutic exercises, neuromuscular re-education and manual therapy were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services. Reimbursement due from the carrier for the medical necessity issues equals **\$759.15**.

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 for dates of service 09-29-04 through 10-14-04 totaling \$759.15 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 5th day of May 2005.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO decision

May 4, 2005

TEXAS WORKERS COMP. COMISSION
AUSTIN, TX 78744-1609

CLAIMANT: ___

EMPLOYEE: ___

POLICY: M5-05-1957-01

CLIENT TRACKING NUMBER: M5-05-1957-01/5278

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 4/6/05, 11 pages

RECORDS RECEIVED FROM THE RESPONDENT:

Summary of records and case received from Syzygy Associates dated 3/10/05, 2 pages

Table of disputed services (TWCC-60) undated, 3 pages

Prescription from Physical Medicine Associates dated 9/21/04, 1 page

Letter of Medical Necessity form for OT evaluation and treatment dated 9/24/04, 1 page

Prescription from Physical Medicine Associates dated 11/4/04, 1 page

Request for reconsideration from Syzygy Assoc dated 12/16/04, 2 pages

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HCFA form for DOS 10/14/04, 1 page
Page 2 of EOB for DOS 10/14/04, 1 page
Office note 10/14/04, 1 page
HCFA form 10/8/04, 1 page
Page 2 of EOB 10/8/04, 1 page
Office note 10/8/04, 1 page
HCFA form 10/1/04, 9/29/04, 2 pages
Page 2 & 3 of EOB for DOS 10/1/04 & 9/29/04, 2 pages
Office notes for DOS 10/1/04, 9/29/04
Rehab Evaluation dated 9/29/04, 3 pages
Letter from George Armstrong MD dated 4/13/04, 9 pages
Communication log 9/22/04–11/11/04, 1 page
Physical Performance Eval from Magnolia Workskills dated 6/28/04, 4 pages

Summary of Treatment/Case History:

The request was if the procedure codes #97003–Occupational therapy evaluation, #97110–Therapeutic exercises, #97112–Neuromuscular re–education, and #97140–Manual therapy are medically necessary three times a week for two weeks from 9/24/04 to 10/14/04 for the diagnoses given, which include myofascial pain, rotator cuff problems, and possible thoracic outlet syndrome.

This patient was referred to occupational therapy. Occupational therapy, more than physical therapy, deals with upper extremity disorders. Therefore, it is not unusual for a shoulder problem to be referred to an occupational therapy setting.

The treatments provided—therapeutic exercises, neuromuscular re–education, and manual therapy—are typical services. Manual therapy includes range of motion exercises and stretching. Certainly, the length of time is not excessive. Whether the diagnoses are accurate cannot be determined from the records provided.

Questions for Review:

Dates of service in dispute: 9/29/04 through 10/14/04:

1. Item(s) in dispute: CPT codes #97003 OT evaluation, #97110 Therapeutic exercises, #97112 Neuromuscular re–education, #97140 Manual therapy, denied by the carrier for Medical Necessity. Please review.

Conclusion/Decision to Certify:

1. Item(s) in dispute: CPT codes #97003 OT evaluation, #97110 Therapeutic exercises, #97112 Neuromuscular re–education, #97140 Manual therapy, denied by the carrier for Medical Necessity. Please review.

The services provided, as noted above are appropriate and necessary for trying to stretch, strengthen, and increase range of motion of an affected shoulder joint for any of the conditions that were diagnosed in this case. Furthermore, two weeks of such therapy at three times a week is not excessive.

(continued)

Applicable Clinical or Scientific Criteria or Guidelines Applied in Arriving at Decision:

According to *Official Disability Guidelines* and the *ACOEM Clinical Practice Guidelines*, 10 visits of medical physical therapeutic treatment over 5 weeks are suggested for rotator cuff problems.

References Used in Support of Decision:

Official Disability Guidelines

ACOEM Clinical Practice Guidelines

The physician who provided this review is a Diplomate of the American Academy of Pain Management, board certified in Physical Medicine and Rehabilitation and Occupational Medicine. This reviewer is a member of the American College of Occupational & Environmental Medicine, the American Association of Electrodiagnostic Medicine, the Wilderness Medical Society, the American Academy of Pain Management and the American Board of Independent Medical Examiners. This reviewer has authored numerous publications and done numerous presentations within their field. This review has been in active practice since 1978.

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.

It is the policy of Medical Review Institute of America to keep the names of its reviewing physicians confidential. Accordingly, the identity of the reviewing physician will only be released as required by state or federal regulations. If release of the review to a third party, including an insured and/or provider, is necessary, all applicable state and federal regulations must be followed.

Medical Review Institute of America retains qualified independent physician reviewers and clinical advisors who perform peer case reviews as requested by MRloA clients. These physician reviewers and clinical advisors are independent contractors who are credentialed in accordance with their particular specialties, the standards of the American Accreditation Health Care Commission (URAC), and/or other state and federal regulatory requirements.

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.