

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 03-29-05.

CPT code 99358-52 date of service 03-26-04 per Rule 133.308(e)(1) was not timely filed and is not eligible for review.

CPT code 99358-52 dates of service 07-22-04 and 09-07-04 with the 52 modifier is invalid for Medicare and will not be part of the review.

The IRO reviewed prolonged physician services, office visits, functional capacity evaluation, neuromuscular stimulator, DME (miscellaneous), self care/home management training, manual therapy technique and massage therapy rendered from 03-26-04 through 09-17-04 that were denied based upon "V".

The IRO determined that the functional capacity evaluation and the self care home management training from 03-26-04 through 09-17-04 **were** medically necessary. The IRO further determined that the prolonged physician services, office visits established patient, manual therapy, neuromuscular stimulator, DME (miscellaneous) and massage therapy from 03-26-04 through 09-17-04 **were not** medically necessary. The amount of reimbursement due from the carrier for the medical necessity issues equals **\$629.59**.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the **majority** of issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

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 05-06-05, 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 99080-73 date of service 09-17-04 denied with a "V" for unnecessary medical treatment based on a peer review; however, the TWCC-73 is a required report per Rule 129.5 and is not subject to an IRO review. 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 dates of service 03-30-04 through 09-17-04 totaling \$644.59 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 24<sup>th</sup> day of May 2005.

Medical Dispute Resolution Officer  
Medical Review Division

Enclosure: IRO Decision

May 20, 2005

TEXAS WORKERS COMP. COMISSION  
AUSTIN, TX 78744-1609

CLAIMANT:  
EMPLOYEE:  
POLICY: M5-05-2116-01  
CLIENT TRACKING NUMBER: M5-05-2116-01 /5278

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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 State:

Notification of IRO assignment dated 05/12/05, 6 pages

Explanation of benefit forms for dates of service 09/7/04 through 05/24/04, 5 pages

Records received from Requestor:

MRI report dated 03/22/04, 1 page

Evaluation summary – functional capacity evaluation dated 06/10/04, 20 pages

Evaluation summary – functional capacity evaluation dated 03/30/04, 16 pages

Functional capacity evaluation dated 07/28/04, 9 pages

Prescription from Dr. Havard III dated 03/30/05, 1 page

Chart notes dated 09/01/04 through 03/30/05, 3 pages

Medical progress evaluations dated 04/07/04 through 03/30/05, 4 pages

Office reports dated 02/07/05, 2 pages

Office notes dated 05/09/03 through 02/20/04, 3 pages

Operative report dated 08/14/03, 2 pages

Peer review dated 02/16/05, 13 pages

Detailed medical history and examination form dated 03/03/04, 4 pages

Orthopedic review dated 01/21/04, 3 pages

Joint evaluations of the shoulder dated 02/26/04 through 05/24/04, 3 pages

Initial narrative report dated 02/26/04, 2 pages

TWCC-69 form dated 08/17/04, 1 page

Report of medical evaluation dated 08/05/04, 2 pages

Review of medical history and physical exam dated 08/05/04, 3 pages

AIRS impairment rating report dated 08/05/04, 3 pages

SOAP notes dated 03/03/04 through 03/30/05, 18 pages

**Summary of Treatment/Case History:**

The claimant was working for \_\_\_\_\_ when a work related injury occurred on \_\_\_\_\_. The patient presented to the offices of Daniel Aldrich, MD on 05/09/03 following a fall on the right shoulder experienced at work. From 05/09/03 through 02/20/04 the patient received treatment from Daniel Aldrich, MD; surgical applications were performed by Daniel Aldrich, MD on 08/14/03 that included right shoulder arthroscopy, subacromial decompression, debridement of the labrum, and distal clavicle resection. A chiropractic evaluation performed by Marsha Miller, DC revealed need for diagnostic imaging. An MR Imaging of the right shoulder performed on 03/22/04 revealed minimal AC joint soft tissue hypertrophy. A chiropractic evaluation was performed on 05/24/04. Chiropractic therapeutics were implemented from 03/17/04 through 03/30/05. Functional capacity evaluations were performed on 03/31/04, 06/10/04, and 07/28/04; an evaluation performed on 06/10/04 revealed necessity for a work conditioning program. On 08/05/04 the claimant consulted with Roby Mize and was placed at MMI on 08/05/04 with a 9% whole person impairment of function. The claimant consulted with Benjamin Cunningham, MD on 09/01/04–09/28/04 which revealed that the claimant was a candidate for a MUA of the shoulder, no tear of the rotator cuff evident. The patient presented to the offices of Philip Elizondo, MD on 02/07/05 and was advised of need for surgical intervention including a decompression of the AC joint. A peer review was performed by Brad McKechnie, DC on 02/16/05.

**Questions for Review:**

The dates of services in dispute are 03/26/04 through 09/17/04. Items in dispute: CPT codes #99354 prolonged physician services, #99213 office Visit established patient, #97750–FC functional capacity evaluation, #E0745 neuromuscular stimulator, #E1399 DME (miscellaneous), #97535 self care/home

management training, #97140-59 manual therapy technique, and #97124 massage denied by the carrier for medical necessity with "V" codes.

**Explanation of Findings:**

Medical necessity is established for the implementation of functional based testing #97750-FC from 03/26/04 through 09/17/04. Medical necessity is established for #97535 self care home management from 03/26/04 through 09/17/04.

Functional based testing and self care home management training is essential for the management of this claimant's condition. Self care may be deemed appropriate for the control of current pain generators.

Medical necessity is not established for #99354 prolonged physician services, #99213 office visit established patient, #97140-59 manual therapy, #E0745 neuromuscular stimulator, #E1399 DME (miscellaneous), #97124 massage from 03/26/04 through 09/17/04.

The claimant sustained a work related injury to the right shoulder as a result of a fall on \_\_\_\_\_. The claimant had arthroscopic surgery performed in August of 2003. The claimant was placed at MMI on 08/05/04. There is not data to support continued treatment passive therapeutic management of this claimant's condition between 03/26/04 and 09/17/04.

There is no data presented for this review that establish clinical rationale for the continued utilization of DME and passive therapeutics in the treatment of this workers condition. Continued course of passive management lacks efficacy to warrant additional trials.

**Conclusion/Partial Decision to Certify:**

Medical necessity is established for the implementation of functional based testing #97750-FC from 03/26/04 through 09/17/04. Medical necessity is established for #97535 self care home management from 03/26/04 through 09/17/04.

Medical necessity is not established for #99354 prolonged physician services, #99213 office visit established patient, #97140-59 manual therapy, #E0745 neuromuscular stimulator, #E1399 DME (miscellaneous), #97124 massage from 03/26/04 through 09/17/04.

**References Used in Support of Decision:**

Ellman H. Arthroscopic subacromial decompression: analysis of one- to three-year results. *Arthroscopy*. 1987;3(3):173-81.

Overview of implementation of outcome assessment case management in the clinical practice. Washington State Chiropractic Association; 2001. 54p.

Philadelphia Panel, Philadelphia Panel evidence-based clinical practice guidelines on selected rehabilitation interventions for shoulder pain, *Phys Ther* 2001 Oct;81(10):1719-30.

Shoulder. Work Loss Data Institute; 2003. 15 p.

Troyanovich SJ, et al. Structural rehabilitation of the spine and posture: rationale for treatment beyond the resolution of symptoms. *J Manipulative Physiol Ther*. 1998 Jan;21(1):37-50.

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The chiropractor providing this review received his degree in chiropractic in 2000. The reviewer is a member of the American College of Sports Medicine, the Meckenzie Institute, the Occupational Injury Prevention and Rehabilitation Society, the International Association of Rehabilitation Professionals and the National Safety Council. The reviewer is pursuing additional qualifications as a diplomate in rehabilitation. They are also pursuing Occupational Health and Safety Technologist certification in preparation for their Certified Safety Boards. The reviewer also works as a review doctor for their state workers compensation commission in the medical dispute resolution process.

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.

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