

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## Retrospective Medical Necessity Dispute

### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (X) HCP ( ) IE ( ) IC	<b>Response Timely Filed?</b> (X) Yes ( ) No
Requestors Name and Address  Kevin Strathdee, D. C. 2121 N. Main St. Ft. Worth, TX 76106	MDR Tracking No.: M5-05-2593-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address  TX Mutual Ins. Company, Box 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

### PART II: SUMMARY OF DISPUTE AND FINDINGS – MEDICAL NECESSITY ITEMS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
9-8-04, -10-04, 9-14-04		CPT code 97110	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
9-15-04, 9-22-04, 9-28-04, 9-29-04, 10-1-04, 10-6-04		CPT code 97150	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
9-8-04, 9-10-04, 9-14-04, 9-15-04, 9-22-04, 9-28-04, 9-29-04, 10-1-04, 10-6-04		CPT code 97140	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
8-2-04	10-6-04	HCPCS code A4595, A4556, A4630, CPT code G0283	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

### PART III: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Commission Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Medical Review Division assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the requestor and respondent.

The Division has reviewed the enclosed IRO decision and determined that the requestor **prevailed** on the majority of the disputed medical necessity issues. The amount due the requestor for the medical necessity issues is \$1,075.61.

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 6-15-05 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 99082-TP in this dispute: Payment for travel is coordinated by the local field office per Rule 134.6. No reimbursement recommended.

Regarding CPT code 97140 on 9-17-04 (2 units): Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). Recommend reimbursement of \$65.80.

Regarding CPT code 97110 on 9-17-04: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Reimbursement not recommended.

CPT code 97535 on 8-2-04 was denied as "G-Global". Per Rule 133.304 (c) the carrier didn't specify which service this was global to, and the 2002 Medicare Fee Schedule does not show that it is global to any service performed on this date of service. It will be reviewed according to 2002 Medicare Fee Schedule. Recommend reimbursement of \$37.04.

CPT code 99455-VR on 9-2-04 was denied as "U – unnecessary medical." According to Rule 134.202 (6)(F) the treating doctor shall bill the medical disability examination with modifier "VR" to indicate a review of the report only. Recommend reimbursement of \$50.00.

**PART IV: COMMISSION DECISION AND ORDER**

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to a refund of the paid IRO fee in the amount of \$460.00. The Division hereby **ORDERS** the insurance carrier to remit \$1,228.45, consistent with the applicable fee guidelines plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Donna Auby

8-24-05

Authorized Signature

Typed Name

Date of Order

**PART V: INSURANCE CARRIER DELIVERY CERTIFICATION**

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: \_\_\_\_\_ Date: \_\_\_\_\_

## **PART VI: YOUR RIGHT TO REQUEST A HEARING**

If you are unhappy with all or part of this decision, you have the right to appeal the decision. Those who wish to appeal decisions that were issued during the month of August 2005, should be aware of changes to the appeals process which take effect September 1, 2005.

House Bill 7, recently enacted by the 79th Texas Legislature, provides that an appeal of a medical dispute resolution order that is not pending for a hearing at the State Office of Administrative Hearings (SOAH) on or before August 31, 2005 is not entitled to a SOAH hearing. This means that the usual 20-day window to appeal to SOAH, found in Commission Rule 148.3, will be shortened for some parties during this transition phase. If you wish to seek an appeal of this medical dispute resolution order to SOAH, you are encouraged to have your request for a hearing to the Commission as early as possible to allow sufficient time for the Commission to submit your request to SOAH for docketing. A request for a SOAH hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas 78744 or faxed to 512-804-4011. A copy of this Decision should be attached to the request.

Beginning September 1, 2005, appeals of medical dispute resolution orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

July 14, 2005

TEXAS WORKERS COMP. COMMISSION  
AUSTIN, TX 78744-1609

CLAIMANT: \_\_\_\_

EMPLOYEE: \_\_\_\_

POLICY: M5-05-2593-01

CLIENT TRACKING NUMBER: M5-05-2593-01 5278

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**Amended Review 8/23/05:**

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:**

FROM THE STATE:

Notification of IRO assignment dated 7/1/05 1 page  
Texas Workers Compensation Commission form dated 7/1/05 1 page  
Medical Dispute Resolution Request/Response form 2 pages  
Provider sheet 1 page  
Table of disputed services 3 pages  
Provider information report 2 pages  
Vendor/payee information report 1 page  
Texas Mutual explanation of benefits dated 8/2/04 1 page  
Texas Mutual explanation of benefits dated 9/2/04 1 page  
Texas Mutual explanation of benefits dated 9/8/04 2 pages  
Texas Mutual explanation of benefits dated 9/10/04 3 pages  
Texas Mutual explanation of benefits dated 9/14/04 4 pages  
Texas Mutual explanation of benefits dated 9/15/04 1 page  
Texas Mutual explanation of benefits dated 9/22/04 1 page  
Texas Mutual explanation of benefits dated 9/28/04 1 page  
Texas Mutual explanation of benefits dated 9/29/04 1 page  
Texas Mutual explanation of benefits dated 10/1/04 1 page  
Texas Mutual explanation of benefits dated 10/6/04 1 page

FROM THE REQUESTOR:

Request for reconsideration dated 3/24/05 2 pages  
Page 8 of chart notes dated 11/4/04 1 page  
Physical performance evaluation dated 10/4/04 1 page  
Texas Injury Clinic Examination cover sheet 1 page  
Occupational injury report dated 6/22/04 2 pages  
Texas Injury Clinic Medical Reports cover sheet 1 page  
Re-examination report dated 9/1/04 2 pages  
Prescription for PT dated 10/7/04 1 page  
History and physical notes dated 10/7/04 1 page  
Prescription for PT 1 page  
History and physical notes dated 5/3/04 2 pages  
Texas Injury Clinic Daily Notes cover sheet 1 page

Daily notes dated 10/6/04 2 pages  
Daily notes dated 10/1/04 2 pages  
Daily notes dated 9/29/04 2 pages  
Daily notes dated 9/28/04 1 page  
Daily notes dated 9/22/04 1 page  
Daily notes dated 9/24/04 1 page  
Daily notes dated 9/17/04 1 page  
Daily notes dated 9/15/04 1 page  
Daily notes dated 9/14/04 1 page  
Daily notes dated 9/10/04 1 page  
Daily notes dated 9/9/04 1 page  
Daily notes dated 9/8/04 1 page  
Daily notes dated 8/16/04 1 page  
Daily notes dated 8/2/04 1 page  
Texas Injury Clinic Rehabilitation cover sheet 1 page  
Shoulder I Rehabilitation protocol report 4 pages  
Texas Injury Clinic Imaging cover sheet 1 page  
MRI report dated 7/3/03 1 page  
Texas Injury Clinic Physical Testing cover sheet 1 page  
Functional capacity evaluation dated 11/4/04 7 pages  
Page 2 of Testing summary dated 10/4/04 1 page  
Physical performance evaluation dated 10/26/04 1 page  
Page 2 of Testing summary dated 10/4/04 1 page  
Physical performance evaluation dated 10/4/04 2 pages  
Request for reconsideration dated 3/24/05 2 pages  
Texas Injury Clinic Examination

FROM THE RESPONDENT:

Texas Injury Clinic Examination cover sheet 1 page  
Occupational injury report dated 6/22/04 2 pages  
Texas Injury Clinic Medical Reports cover sheet 1 page  
Re-examination report dated 9/1/04 2 pages  
Prescription for PT dated 10/7/04 1 page  
History and physical dated 10/7/04 1 page  
Prescription for PT 1 page  
History and physical dated 5/3/04 2 pages  
Texas Injury Clinic Daily notes cover sheet 1 page  
Daily notes dated 10/6/04 2 pages  
Daily notes dated 10/1/04 2 pages  
Daily notes dated 9/29/04 2 pages  
Daily notes dated 9/28/04 1 page  
Daily notes dated 9/22/04 1 page  
Daily notes dated 9/24/04 1 page  
Daily notes dated 9/17/04 1 page  
Daily notes dated 9/15/04 1 page  
Daily notes dated 9/14/04 1 page  
Daily notes dated 9/10/04 1 page  
Daily notes dated 9/9/04 1 page  
Daily notes dated 9/8/04 1 page  
Daily notes dated 8/16/04 1 page  
Daily notes dated 8/2/04 1 page  
Texas Injury Clinic Rehabilitation cover sheet 1 page  
Shoulder I Rehabilitation Protocol report dated 10/20/04 4 pages  
Texas Injury Clinic Imaging cover sheet 1 page  
MRI report dated 7/3/03 1 page  
Texas Injury Clinic Physical Testing cover sheet 1 page  
Functional Capacity Evaluation report dated 11/4/04 8 pages  
Physical performance evaluation report dated 10/4/04 2 pages  
Physical performance evaluation report dated 10/26/04 2 pages  
Physical performance evaluation report dated 10/4/04 2 pages  
Copy of check from Health Builders Chiropractic dated 7/8/05 1 page

**Summary of Treatment/Case History:**

The patient, a 33-year-old male, who sustained a work-related injury on \_\_\_ and he underwent a right shoulder MRI study on 7/3/03 that revealed an osseous contusion of the head of the humerus, tear of the posterior rim of the glenoid labrum, and probable tear of the anterior rim of the glenoid labrum. There was no evidence of rotator cuff tear.

The patient underwent an orthopedic surgical evaluation with Joseph Daniels DO on 5/3/04 and he had received exercises, physical therapy, injections, and medications. He was diagnosed with anterior impingement syndrome, AC joint pain, and SLAP lesion of the right shoulder. Surgery was recommended, to be followed by a period of post-operative physical therapy.

The 6/22/04 report from Kevin Strathdee DC indicated that the patient was referred over by his orthopedist and his arm was in a sling prescribed by the surgeon. No treatments were administered.

The patient was re-examined by the chiropractor on 8/2/04 and continued TENS unit usage was recommended.

The patient was re-examined by the chiropractor on 9/1/04 and he underwent surgical repair of the shoulder on 6/1/04. He had undergone six sessions of aquatic therapy and was released for land-based rehabilitation exercises. He was also using a TENS unit at home and was performing home-based flexibility exercises prescribed by the surgeon. The patient was scheduled to begin rehabilitation on 9/7/04. The patient was treated with rehabilitation exercises, manual therapy, electrical stimulation, and group therapeutic procedures on the following dates in varying combinations:

9/8/04, 9/9/04, 9/10/04, 9/14/04, 9/15/04, 9/17/04, 9/22/04, 9/24/04, 9/25/04, 9/29/04, 10/1/04, 10/6/04, 10/11/04, 10/14/04, 10/18/04, 10/20/04, and 10/22/04.

The patient underwent a physical performance test on 10/4/04 with the chiropractor and global active range of motion restrictions were reported. Deficits in shoulder strength were also reported.

The patient was re-examined by the orthopedist on 10/7/04 and the patient stated he was doing well until recently, when he was performing a functional capacity evaluation and his shoulder popped during the testing, resulting in increased shoulder pain. The examination revealed normal active ranges of motion and positive impingement signs. He was administered a shoulder injection and more post-operative PT was prescribed.

**Questions for Review:**

1. Services in question for medical necessity: TENS supplies (#A4595-NU), electrodes (#A4556-NU)/ batteries (#A4630-NU), electrical stimulation (#G0283), manual therapy technique (#97140-59) therapeutic exercise (#97110-59) and group therapeutic procedures (#97150).

**Explanation of Findings:**

The use of therapeutic exercises (#97110) on 9/8/04, 9/10/04, and 9/14/04, was medically necessary. The use of manual therapy (#97140) 9/8/04, 9/10/04, 9/14/04, 9/15/04, 9/22/04, 9/28/04, 9/29/04, 10/1/04, and 10/6/04 was medically necessary for management of the patient's shoulder range of motion restrictions. The use of group therapeutic procedures (#97150) was medically necessary on 9/15/04, 9/22/04, 9/28/04, 9/29/04, 10/1/04, and 10/6/04.

The use of TENS supplies (#A4595-NU), electrodes (#A4556-NU), batteries (#A4630-NU), and electrical stimulation (#G0283) from 8/2/04 to 10/6/04 were not medically necessary, as the use of electrical stimulation is not supported in the management of shoulder pain.

According to the Philadelphia Panel's Evidence-Based Guidelines on Selected Rehabilitation Interventions for Shoulder Pain, none of the modalities used in the treatment of the patient were supported by the study. Ultrasound provided clinically important pain relief relative to a control for patients with calcific tendinitis in the short term (less than 2 months). There was good agreement with this recommendation from practitioners (75%). For several interventions and indications (eg, thermotherapy, therapeutic exercise, massage, electrical stimulation, mechanical traction), there was a lack of evidence regarding efficacy. (Philadelphia Panel Evidence-Based Guidelines on Selected Rehabilitation Interventions for Shoulder Pain. Phys Ther. 2001;81:1719-1730)

Green et al conducted a study to determine the efficacy of physiotherapy interventions for disorders resulting in pain, stiffness and/or disability of the shoulder. Combining mobilization with exercise resulted in additional benefit when compared to exercise alone for rotator cuff disease. Laser therapy was demonstrated to be more effective than placebo for adhesive capsulitis but not for rotator cuff tendinitis. Both ultrasound and pulsed electromagnetic field therapy resulted in improvement compared to placebo in pain in calcific tendinitis. There is no evidence of the effect of ultrasound in shoulder pain (mixed diagnosis), adhesive capsulitis or rotator cuff tendinitis. When compared to exercises, ultrasound is of no additional benefit over and above exercise alone. There is some evidence that for rotator cuff disease, corticosteroid injections are superior to physiotherapy and no evidence that physiotherapy alone is of benefit for Adhesive Capsulitis (Green SE, Buchbinder R, Hetrick S. Physiotherapy interventions for shoulder pain. The Cochrane Database of Systematic Reviews 2003, Issue 2. Art. No.: CD004258. DOI: 10.1002/14651858.CD004258)

MedRisk Expert Clinical Benchmarks indicate that treatment of non-complicated surgical shoulder disorders should encompass no more than 20 visits over a period of ten weeks and treatment of complicated surgical shoulder disorders should encompass no more than 36 visits over a treatment period of 18 weeks (Expert Clinical Benchmarks: Upper Extremity – Shoulder and Elbow Guideline, King of Prussia, PA, MedRisk, Inc. 2004).

**Conclusion/Partial Decision to Certify:**

1. Services in question for medical necessity: TENS supplies (#A4595-NU), electrodes (#A4556-NU)/ batteries (#A4630-NU), electrical stimulation (#G0283), manual therapy technique (#97140-59) therapeutic exercise (#97110-59) and group therapeutic procedures (#97150).

The use of therapeutic exercises (#97110) on 9/8/04, 9/10/04, and 9/14/04, was medically necessary.

The use of group therapeutic procedures (#97150) was medically necessary on 9/15/04, 9/22/04, 9/28/04, 9/29/04, 10/1/04, and 10/6/04.

The use of manual therapy (#97140) 9/8/04, 9/10/04, 9/14/04, 9/15/04, 9/22/04, 9/28/04, 9/29/04, 10/1/04, and 10/6/04 was medically necessary for management of the patient's shoulder range of motion restrictions

**Conclusion/Partial Decision to Not Certify:**

The use of TENS supplies (#A4595-NU), electrodes (#A4556-NU), batteries (#A4630-NU), and electrical stimulation (#G0283) from 8/2/04 to 10/6/04 were not medically necessary.

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

Philadelphia Panel Evidence-Based Guidelines on Selected Rehabilitation Interventions for Shoulder Pain. Phys Ther. 2001;81:1719-1730

**References Used in Support of Decision:**

Green SE, Buchbinder R, Hetrick S. Physiotherapy interventions for shoulder pain. The Cochrane Database of Systematic Reviews 2003, Issue 2. Art. No.: CD004258. DOI: 10.1002/14651858.CD004258)

Expert Clinical Benchmarks: Upper Extremity – Shoulder and Elbow Guideline, King of Prussia, PA, MedRisk, Inc. 2004

This review was provided by a Doctor of Chiropractic who is also a member of the American Chiropractic Academy of Neurology. This reviewer also holds a certification in Acupuncture. This reviewer has fulfilled both academic and clinical appointments and currently serves as an assistant professor at a state college, is in private practice and is a director of chiropractic services. This reviewer has previously served as a director, dean, instructor, assistant professor, and teaching assistant at a state college and was responsible for course studies consisting of pediatric and geriatric diagnosis, palpation, adjusting, physical therapy, case management, and chiropractic principles. This reviewer is responsible for multiple postgraduate seminars on various topics relating to chiropractics and has authored numerous publications. This reviewer has participated in numerous related professional activities including work groups, committees, consulting, national healthcare advisory committees, seminars, National Chiropractic Coalition, media appearances, and industrial consulting. This reviewer has been in practice since 1986.

MRIOA 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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