



Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity and Fee Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address:	MDR Tracking No.: M5-05-3102-01
Brad Burdin DC 9502 Computer Drive Suite 100 San Antonio TX 78229	Claim No.:
	Injured Worker's Name:
Respondent's Name and Address: Box 17	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Medical Dispute Resolution Request package, EOBs, CMS-1500s. Per statement on table of disputed services, "These treatments were deemed medically necessary for treatment of the work related injury in doctor's professional judgment and IE's need."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Medical Dispute Resolution Response. No position summary submitted.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
8-25-04 to 10-4-04	97110, 97140, 97035, 99213	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00

PART V: 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 Division Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), Medical Dispute Resolution 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 did **not** prevail on the disputed medical necessity issues.

Based on review of the disputed issues within the request, the 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 Medical Dispute Resolution.

Code 97750-VR billed on date of service 11-24-04 was paid @ \$34.30 with denial code F, the charge for this procedure exceeds the fee schedule or usual and customary allowance. Rule 134.202 (b) states that Texas Workers' Compensation system participants shall apply the Medicare program reimbursement coding, billing, and reporting payment policies in effect on the date a service is provided. Rule 133.1(a)(3)(C) states that a complete medical bill includes correct billing codes from Commission fee guidelines in effect on the date of service.

The requestor billed code 97750-VR. This modifier is invalid with this code; therefore, no review and no additional reimbursement recommended.

Per telecon today with requestor, the required report billed on date of service 10-4-04 was paid on 11-18-04. Therefore, no dispute exists.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.202

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

Medical Dispute Officer

11-2-04

Authorized Signature

Typed Name

Date

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and 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. The Division is not considered a party to the appeal.

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

NOTICE OF INDEPENDENT REVIEW

NAME OF PATIENT:
IRO CASE NUMBER: M5-05-3102-01
NAME OF REQUESTOR: Brad Burdin, D.C.
NAME OF PROVIDER: Brad Burdin, D.C.
REVIEWED BY: Board Certified in Chiropractics
IRO CERTIFICATION NO: IRO 5288
DATE OF REPORT: 10/06/05 (REVISED 11/01/05)

Dear Dr. Burdin:

Professional Associates has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO) (#IRO5288). Texas Insurance Code Article 21.58C, effective September 1, 1997, allows a patient, in the event of a life-threatening condition or after having completed the utilization review agent's internal process, to appeal an adverse determination by requesting an independent review by an IRO.

In accordance with the requirement for TDI-Division of Workers' Compensation (DWC) to randomly assign cases to IROs, DWC has assigned your case to Professional Associates for an independent review. The reviewing physician selected has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, the reviewing physician reviewed 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. determination, and any documentation and written information submitted in support of the appeal.

This case was reviewed by a physician reviewer who is Board Certified in the area of Chiropractics and is currently listed on the DWC Approved Doctor List.

I am the Secretary and General Counsel of Professional Associates and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for determination prior to referral to the Independent Review Organization.

REVIEWER REPORT

Information Provided for Review:

An evaluation with Brad Burdin, D.C. at Neuromuscular Institute of Texas-P.A. dated 01/12/04

An MRI and x-rays of the right shoulder dated 01/23/04 and interpreted by Raul Pelaez, M.D.

A TWCC-73 form signed by Patrick Wilson, M.D. on 02/02/04

An initial Physical Performance Evaluation (PPE) and impairment rating summary dated 02/13/04 from an unknown provider (the signature was illegible)

A prescription for rehabilitation dated 02/16/04 from an unknown physician (the signature was illegible)

Treatment with Dr. Burdin at the Neuromuscular Institute of Texas-P.A. on 02/16/04, 02/18/04, 02/20/04, 02/23/04, 02/25/04, 02/27/04, 03/01/04, 03/03/04, 03/05/04, 03/08/04, 03/10/04, 03/12/04, 03/15/04, 03/17/04, 03/19/04, 03/22/04, 03/24/04, 03/25/04, 03/26/04, 03/29/04, 03/31/04, 04/02/04, 04/05/04, 04/07/04, 04/09/04, 07/08/04, 07/09/04, 07/12/04, 07/14/04, 07/16/04, 07/19/04, 07/21/04, 07/23/04, 07/26/04, 07/28/04, 07/30/04, 08/02/04, 08/02/04, 08/04/04, 08/06/04, 08/09/04, 08/11/04, 08/13/04, 08/16/04, 08/18/04, 08/20/04, 08/23/04, 08/25/04, 08/27/04, 08/30/04, 09/08/04, 09/09/04, 09/10/04, 09/13/04, 09/15/04, 09/17/04, 09/20/04, 09/22/04, 09/24/04, 09/27/04, 09/29/04, and 10/01/04

Upper extremity evaluations by Dr. Wilson dated 03/02/04, 03/22/04, 04/19/04, 05/24/04, and 06/24/04

Follow-up evaluations with Dr. Burdin dated 03/15/04, 04/19/04, 05/17/04, and 07/07/04

A Required Medical Evaluation dated 03/16/04 from Fred Olin, M.D., an orthopedic surgeon

A follow-up PPE with the unknown provider on 03/16/04 and 04/19/04

An operative report dated 06/16/04 from Dr. Wilson

A prescription for occupational therapy at the Neuromuscular Institute of Texas-P.A. dated 06/24/04

Additional upper extremity evaluations with Dr. Wilson dated 07/08/04, 08/05/04, 09/02/04, 09/30/04, and 11/11/04
Further evaluations with Dr. Burdin on 08/02/04, 09/03/04, 10/04/04, 10/13/04, 11/18/04, and 11/24/04
Another prescription for occupational therapy at the Neuromuscular Institute of Texas-P.A. dated 08/02/04
An initial evaluation for therapy dated 08/02/04 at Neuromuscular Institute of Texas-P.A.
A prescription for occupational therapy at the Neuromuscular Institute-P.A. dated 09/03/04
An occupational therapy reevaluation dated 09/08/04 from an unknown provider at Neuromuscular Institute of Texas-P.A.
An occupational therapy reevaluation from an unknown provider (the signature was illegible) at the Neuromuscular Institute of Texas-P.A. on 09/08/04
Another prescription for therapy dated 09/30/04 from Dr. Wilson
A therapy discharge dated 10/05/04 from the unknown provider at Neuromuscular Institute of Texas-P.A.
A summary of a Functional Capacity Evaluation (FCE) dated 10/05/04 by Dr. Burdin
A request for occupational therapy from Dr. Burdin dated 11/18/04
Another FCE summary dated 11/22/04 from Dr. Burdin
A TWCC-73 form signed by Dr. Burdin on 01/13/05
An impairment rating evaluation performed by Dr. Burdin on 02/10/05
A TWCC-69 form signed by Dr. Burdin on 02/10/05
A TWCC-73 form signed by Dr. Burdin on 02/10/05
A position statement from the Neuromuscular Institute of Texas-P.A. dated 09/01/05

Clinical History Summarized:

The patient, a 54-year-old male, was injured on the job on or about _____. He was employed as a customer service technician for when he injured his right shoulder. The patient's initial office visit was on 01/12/04 and he underwent approximately eight weeks, totaling 23 sessions, of conservative treatment from 02/16/04 through 04/09/04 with Dr. Burdin. The patient underwent surgery on the right shoulder, which consisted of a modified Munford procedure, a partial acromionectomy, and claviculectomy, and repair of the rotator cuff on 06/16/04 by Dr. Wilson. The patient subsequently underwent postsurgical therapy from 07/08/04 through 09/29/04, which was a period of 13 weeks for a total of 35 additional sessions. The patient was felt to have reached clinical Maximum Medical Improvement (MMI) as of 02/10/05 and was assigned 11% impairment rating by Dr. Burdin.

Disputed Services:

Therapeutic exercises, manual therapy technique, ultrasound, and office visits from 08/25/04 through 10/04/04

Decision:

I disagree with the requestor. The treatment from 08/24/04 through 10/04/04 was neither reasonable nor necessary.

Rationale/Basis for Decision:

Based upon a review of the records, it is my opinion that the documentation did not support that the treatment with therapeutic exercises, manual therapy techniques, ultrasound, and office visits for 08/25/04 through 10/04/04 as reasonable and medically necessary as related to the injury of _____. Records indicated that the patient incurred an injury to the right shoulder and underwent 23 sessions of therapy and rehabilitation from 02/16/04 through 04/09/04, which was unsuccessful. Subsequently, the patient underwent surgical repair of the right shoulder on 06/16/04 and then began postsurgical rehabilitation as of 07/08/04. Records indicated that from the period beginning 07/08/04 through 08/23/04, which was approximately eight weeks of care, the patient underwent 21 sessions of both passive and active therapy. Continued treatment with passive modalities and therapeutic exercises in the office setting beyond 08/24/05 would not be reasonable or medically indicated. Based upon guidelines set forth in Chapter 9, Pages 195 through 226, of the *ACOEM Guidelines*, which pertain specifically to the shoulder and upper extremity, it is noted that specific recommendations are made on the use of passive physical modalities. Specifically, on Page 203, it was noted that physical modalities such as massage, diathermy, laser treatment, ultrasound treatment, transcutaneous electrical neurostimulation (TENS) unit, and biofeedback are not supported by high quality medical studies, but they may be useful in the initial conservative treatment of acute shoulder symptoms, depending upon the experience of local physical therapists available for referral. Some medium quality evidence support manual physical therapy, ultrasound, and high energy extra corporeal shockwave therapy for calcifying tendonitis of the shoulder. Claimant at-home applications of heat or cold packs may be used before or after exercises and are as effective as those performed by a therapist. Furthermore, on Page 212, referencing Table 9-6, it was noted that under physical treatment methods, activities, and exercise, the only recommendation was to maintain activities of other

parts of body while recovering, maintain passive range of motion of the shoulder with pendulum exercises, and to treat initially with strengthening and stabilization exercises for impingement syndrome, rotator cuff tear, instability, and recurrent dislocation. Optional included at home applications of heat or cold packs to aid exercises and a short course of supervised exercise instruction by the therapist. Passive modalities by a therapist, unless accompanied by teaching the claimant exercises to be carried out at home, was not recommended.

This review was conducted on the basis of medical and administrative records provided with the assumption that the material is true and correct.

This decision by the reviewing physician consulting for Professional Associates is deemed to be a Commission decision and order.

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. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). 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.

If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision. A request for a hearing should be faxed to 512-804-4011 or sent to:

Chief Clerk of Proceedings/Appeals Clerk
TDI-Division of Workers' Compensation
P. O. Box 17787
Austin, TX 78744

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization's decision was sent to DWC via facsimile or U.S. Postal Service on 11/01/05 from the office of Professional Associates.

Sincerely,

Amanda Grimes
Secretary/General Counsel