MDR Tracking Number: M5-03-2364-01

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 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 05-20-03. In accordance with Rule 133.307(d)(1) A dispute on a carrier shall be considered timely if it is filed with the division no later then one year after the dates of service in dispute therefore dates of service in dispute for 03-25-02 through 05-06-02 are considered untimely.

The IRO reviewed office visits, therapeutic exercises, myofasical release, massage therapy, prolonged service without contact, and medical reports rendered from 05-27-02 through 12-26-02 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity for office visits, myofasical release, massage therapy, prolonged service without contact, medical reports and therapeutic exercises from 05-27-02 through 07-01-02 and 08-12-02 through 12-26-02. Consequently, the requestor is not owed a refund of the paid IRO fee.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity for therapeutic exercises for 07-02-02 through 08-02-02. 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 October 10, 2003, 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.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursemet)	Reference	Rationale
05-20-02, 06-03-02, 06-17-02, 07-01-02, 07-15-02, 07-31-02, 08-13-02, 09-03-02, 09-23-02, 10-25-02	99080-73 (10 units)	15.00/ unit	$0.00	F	Per 129.5(d)	Rule 129.5	Work status report copies submitted confirm delivery of service and were filed in the form and manner prescribed by the Commission. Recommended Reimbursement $150.00 (15.00 for 10 units)
07-03-02, 07-01-02, 08-16-02, 12-18-02	99358-52 (4 units)	$42.00/ unit	$0.00	N	$84.00/ unit	MFG CPT Descriptor	Documentation submitted for review of records meets documentation requirements and confirms delivery of service. Recommended Reimbursement $168.00 ($42.00 for 4 units)
TOTAL		$318.00					The requestor is entitled to reimbursement of **$ 318.00**

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 in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 8-28-01 through 12-28-01 in this dispute.

This Decision is hereby issued this 10th day of February 2004.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

REVISED 10/10/03

August 15, 2003

MDR Tracking Number: M5-03-2364-01
IRO Certificate# 5259

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or

rendered services is determined by the application of medical screening criteria published by ___, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY

Documentation available from file suggest that this individual was injured at work on ___ while moving furniture as a normal function of his job. It appears that he presented initially to his chiropractor on 3/5/02 and was diagnosed with non-specific internal derangement, myospasm and rotator cuff syndrome. X-rays apparently suggest mild degenerative acromio-clavicular change only. The patient receives daily treatment with manipulation and multiple passive modalities. No initial exam or evaluation report is provided for review. The doctor does submit patient records and SOAP notes for services performed 5/27/02 to 11/6/02 only. The majority of treatment provided during this period appears to involve manipulation, myofascial release, and therapeutic exercise. No functional capacity evaluation appears to be performed. There is an orthopedic evaluation made with an ___, on 6/7/02. He identifies a left shoulder impingement type of injury that has failed conservative care to date. No neurological deficits are noted. ___ does review and MRI study (date unknown) that apparently identifies subacromial bursitis without evidence of rotator cuff tear (report not submitted for review). Recommendations are made for subacromial decompression surgery to be performed on 6/11/02. No additional operative or follow-up orthopedic reports are submitted for review. A psychological evaluation is made with a ___, on 8/1/02 suggesting that the patient is experiencing post surgical pain without any significant psychological issues identified. He also notes that the patient has no plans to return to work. There is a repeat MRI of the left shoulder submitted from 12/16/02 suggesting tenosynovitis of the long head of the biceps and supraspinatus with acromio humeral impingement. Again, no orthopedic follow-up evaluations are submitted for review.

REQUESTED SERVICE (S)

Determine medical necessity for chiropractic services (therapeutic exercises, office visits, myofascial release, massage therapy, prolonged service without contact, and medical reports) rendered 5/20/02 through 12/26/02.

Based on available documentation, there does not appear to be rationale for conservative care within the first two weeks following this reported injury. Appropriate advanced imaging and orthopedic consultation would have been indicated at this time.

As there are no chiropractic notes or reports submitted from this period, specific medical necessity for these services cannot be determined. Orthopedic assessment of 6/7/02 suggest that all conservative treatments have failed to date. Some level of post-surgical physical therapy and rehabilitation does appear indicated, however, there is no indication that this should exceed 4 weeks duration unless specifically requested by the orthopedic surgeon based on objective functional deficits. No specific functional deficits are noted in chiropractic reporting.

DECISION

Active post surgical rehabilitation (therapeutic exercise) **is medically necessary** from 7/2/02 through 8/2/02 only. All other services are not considered to be medically necessary.

RATIONALE/BASIS FOR DECISION

[AHCPR Shoulder Treatment Guidelines, GCQAPP Mercy Center Consensus Conference] 1990 RAND Consensus Panel: "a trial course of two weeks using manipulative procedures is indicated before considering treatment/care to have failed. Without evidence of improvement over this time frame, manipulation is no longer indicated. Appropriate specialty or surgical consultation would be necessary."

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, and additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its finds are based solely on submitted materials.

No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned claimant. These opinions rendered do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.