MDR Tracking Number: M5-03-2371-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 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 requestor submitted a medical dispute resolution request on 5/19/03 and was received in the Medical Dispute Resolution on 5/22/03. The disputed date of service 5/21/02 is not within the one year jurisdiction in accordance with Rule 133.308(e)(1) and will be excluded from this Finding and Decision.

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(q)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $450.00** 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 therapeutic procedure (code 97110) was found to be medically necessary until 7/9/02. The office visits on 6/20/02, 7/5/02, 8/22/02, 9/20/02 and 9/27/02 were found to be medically necessary. The muscle testing completed on 6/20/02 and 7/5/02 as well as ROM completed on 6/19/02 and 7/3/02 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for these outpatient service charges.

This Finding and Decision is hereby issued this 12th day of August 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

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 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 Order is applicable to dates of service from 6/13/01 to 9/27/02 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 12th day of August 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/crl

NOTICE OF INDEPENDENT REVIEW DECISION

Date: August 1, 2003

RE: MDR Tracking #: M5-03-2371-01
IRO Certificate #: 5242

_____ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to _____ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

_____ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, 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 was reviewed.

The independent review was performed by a Chiropractic physician reviewer. The Chiropractic physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

It appears the claimant injured her left shoulder and left sided neck area while packing boxes in an assembly line type position while working for a temporary agency. She was required to occasionally lift 15-30 pounds. The claimant was reportedly treated by a company doctor and released to return to work without restrictions after 2 weeks of physical therapy. Her pain continued, however, and she presented some 5 months later to _____ for chiropractic care. The claimant ended up being referred to an orthopedic surgeon due to failure of conservative treatment to progress her condition and a rotator cuff repair and acromioplasty surgery was done on 4/2/02. This was an open surgery and was not really considered arthroscopic. The claimant initiated some post surgical physical therapy on 5/2/02. The claimant underwent a designated doctor exam on 6/5/02 by _____ and was found to not be at maximum medical improvement because she was still exhibiting some functional deficits. Maximum medical improvement was estimated to be 9/5/02 and _____ felt that up to 6 months of time was needed for the claimant to regain her maximum functional abilities following the type of surgery she underwent. It appears that work hardening was completed around 9/4/02. A chiropractic peer review of 3/7/02 and 3/25/02 were reviewed. The claimant underwent some diagnostic work up for her cervical spine as well; however, this appeared to reveal only a degenerative disc problem in the neck. A 6/7/02 follow up from the orthopedic surgeon revealed that the claimant was still in need of some active rehab. Multiple range of motion studies were provided for review as well today. The documentation shows the claimant's range of motion and strength to show excellent improvement from 6/20/02 through 7/3/02. The claimant did show appreciable gains in strength more so than range of motion.

Requested Service(s)

The medical necessity of the outpatient services including therapeutic procedures, analysis of computer data, office visits, range of motion measurements, and sensory nerve conduction studies from 5/21/02 through 9/20/02. This would also include physical performance tests throughout that time period.

Decision

I disagree with the insurance carrier and find that the services billed at 97110 were reasonable and medically necessary until 7/9/02 at which point further services billed at 97110 would not be considered medically necessary. I disagree with the insurance carrier and find that the office visit codes billed at 99213 were reasonable and medically necessary on 5 occasions only during the disputed range of services to include 6/20/02, 7/5/02, 8/22/02, 9/20/02 and 9/27/02. Any and all other office visits billed besides these 5 dates of services would be not be considered medically necessary. I further disagree with the insurance carrier and find that the services billed to include 97750MT and 95851 billed for 6/20/02 and 7/5/02 as well as on 5/21/02, 6/19/02 and 7/3/02 would be considered reasonable and medically necessary. I agree with the insurance carrier and find that all other office visits, therapeutic exercises and unlisted diagnostic procedures were not medically necessary, especially those beyond 7/9/02 except where mentioned above. I agree with the insurance carrier and find that the code 95999-WP as billed on 6/13/02 was not medically necessary.

Rationale/Basis for Decision

With respect to the 97110 services, these were of the active care variety and were considered reasonable and medically necessary through 7/9/02. The rationale for this is that the previous chiropractic peer review did feel the services rendered through 7/9/02 would be considered reasonable and medically necessary. It should also be mentioned that as of this date the claimant had reportedly undergone about 29 such visits and the highly evidence based Official Disability Guidelines recommend 24 visits over a 14 week period for post operative management of this type of surgery. Also as of the range of motion and strength testing of 7/3/02 and 7/5/02, the claimant had shown very good progress and it was my opinion she could have been transitioned at that point into a work hardening program as the treatment by 7/9/02 would have exceeded the recommended guidelines and the claimant appeared to be doing quite well enough such that she could have been transitioned into a work hardening program. As far as the office visits as billed at 99213, the claimant was literally billed 22 times for office visits from 6/13/02 through 9/27/02 and a majority of these were not considered reasonable or medically necessary. It is not medically necessary for a claimant who is undergoing post surgical rehabilitation to see her physician at this frequency when she is simply undergoing a physical therapy program. The chiropractic documentation of the office visits during this time period shows the office visits to be extremely repetitive and there was no need to see the claimant 3 and 4 times per week to simply document that she was doing essentially the same. I do feel that the office visits as billed on 6/20/02, 7/5/02, 8/22/02. 9/20/02 and 9/27/02 were considered medically necessary; however, any and all other office visits during the dispute range of services would not be considered medically necessary. The 5 office visits that I do consider medically necessary are in conjunction with either a re-evaluation or the initiation and correlation of work hardening and therefore these would be considered medically necessary for monitoring purposes and re-evaluation purposes. As far as the 97750MT codes that were billed, these were range of motion or strength evaluations that were important to show progress in the claimant's condition and these were billed on 6/20/02 and 7/5/02, and I would consider them medically necessary to document patient progress. As far as the 95851 codes, these appear to be related to range of motion and these would also be considered medically necessary for documentation purposes with respect to progression and to show that the claimant was progressing. As far as the remaining office visits and therapeutic activities, I have already provided a rationale for this. As far as the 95999-WP code is concerned, there was no documentation in the office visit on 6/13/02 to substantiate that test which is documented to be billed as an unlisted neuromuscular procedure or diagnostic study. I saw no evidence in the 6/13/02 chiropractic note that any of this type of service was done, and I saw no other documentation in the documentation provided for review that documented that this study was done. Therefore it would not be considered medically necessary.