

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 09-07-04.

The IRO reviewed electrical stimulation, office visits, therapeutic exercises and manual therapy technique rendered from 12-17-03 through 07-07-04 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. 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 10-12-04, 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 95903 (4 units) date of service 05-18-04 denied with denial code "F" (fee guideline MAR reduction). The carrier made no payment. Per the Medical Fee Guideline effective 08-01-03 reimbursement is recommended in the amount of \$351.56 ($\$70.31 \times 125\% = \87.89×4 units).

CPT code 95904 (6 units) date of service 05-18-04 denied with denial code "F" (fee guideline MAR reduction). The carrier made no payment. Per the Medical Fee Guideline effective 08-01-03 reimbursement is recommended in the amount of \$421.20 ($\$56.16 \times 125\% = \70.20×6 units).

CPT code 95934 (2 units) date of service 05-18-04 denied with denial code "F" (fee guideline MAR reduction). The carrier made no payment. Per the Medical Fee Guideline effective 08-01-03 reimbursement is recommended in the amount of \$94.82 ($\$37.93 \times 125\% = \47.41×2 units).

CPT code 95861 (1 unit) date of service 05-18-04 denied with denial code "F" (fee guideline MAR reduction). The carrier made no payment. Per the Medical Fee Guideline effective 08-01-03 reimbursement is recommended in the amount of \$147.43 ($\$117.94 \times 125\%$).

CPT code 95900 (2 units) date of service 05-18-04 denied with denial code "F" (fee guideline MAR reduction). The carrier made no payment. Per the Medical Fee Guideline effective 08-01-03 reimbursement is recommended in the amount of \$164.92 ($\$65.97 \times 125\% = \82.46×2 units).

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 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 Decision is applicable for date of service 05-18-04 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 Findings and Decision and Order are hereby issued this 28th day of December 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

Enclosure: IRO Decision

October 27, 2004

TEXAS WORKERS COMP. COMISSION
AUSTIN, TX 78744-1609

CLAIMANT:
EMPLOYEE:
CLIENT TRACKING NUMBER: M5-05-0117-01
IRO CERTIFICATION NUMBER: 52778

Medical Review Institute of America (MRloA) 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 MRloA for independent review in accordance with TWCC Rule 133 which provides for medical dispute resolution by an IRO.

MRloA 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 MRloA for independent review.

Records Received:Records Received from the State of Texas:

1. Notification of IRO assignment dated 10/12/04 (1 page)
2. IRO assignment form dated 10/11/04 (1 page)
3. Medical dispute resolution request/response form dated 9/7/04 (1 page)
4. Medical dispute resolution request/response form dated 9/27/04 (2 pages)
5. List of claim numbers, provider names, addresses, phone numbers and IRS numbers dated 9/15/04 (2 pages)
6. Table of disputed services for dates of service 12/17/03 through 7/7/04 (7 pages)
7. Explanation of benefit forms for dates of service 12/29/03 through 7/7/04 (19 pages)

Records Received from the Requestor:

8. Medical dispute resolution request/response form, undated (2 pages)
9. Table of disputed services for dates of service 12/17/03 through 7/7/04 (8 pages)
10. HICFA forms for dates of service 12/17/03 through 7/7/04 (16 pages)
11. Explanation of benefit forms for dates of service 12/29/03 through 7/7/04 (39 pages)
12. Rehabilitation sheets dated 12/12/03 through 7/16/04 (10 pages)
13. SOAP notes dated 12/17/03 through 7/7/04 (14 pages)
14. Subsequent and specific report dated 1/8/04 (2 pages)
15. Subsequent and specific report dated 3/10/04 (3 pages)
16. Subsequent and specific report dated 4/23/04 (3 pages)
17. Procedure report dated 5/18/04 (6 pages)
18. Office notes from Orthopedic Care Center dated 11/13/03 through 4/2/8/04 (8 pages)
19. TWCC-69 Report of medical evaluation dated 1/29/03 (1 page)
20. Letter from Dr. Granberry dated 1/29/04 (2 pages)
21. TWCC-69 Report of medical evaluation dated 7/19/04 (1 page)
22. Letter from Dr. Ciepiela (5 pages)

Summary of Treatment/Case History:

The claimant underwent 3 MRIs, 3 surgeries and physical medicine treatments after injuring her left shoulder when a patient rolled onto her left arm on ____.

Questions for Review:

This is an amended review. The dates of service in dispute are 12/17/03 through 7/7/04. Please advise medical necessity of #97032-Electrical Stimulation, #99212-Office Visit, #99213-Office Visit, #99214-Office Visits, #97110-Therapeutic Exercises and #97140-Manual Therapy Technique to treat this patient's injury?

Explanation of Findings:

Decision: No, #97032-Electrical Stimulation, #99212-Office Visit, #99213-Office Visit, #99214-Office Visits, #97110-Therapeutic Exercises and #97140-Manual Therapy Technique were not medically necessary to treat this patient's injury.

Rationale: Physical medicine is an accepted part of a rehabilitation program following surgery. However, for medical necessity to be established, there must be an expectation of recovery or improvement within a reasonable and generally predictable time period. In addition, the frequency, type and duration of services must be reasonable and consistent with the standards of the health care community. General expectations include: (A) As time progresses, there should be an increase in the active regimen of care, a decrease in the passive regimen of care and a decline in the frequency of care. (B) Home care programs should be initiated near the beginning of care, include ongoing assessments of compliance and result in fading treatment frequency. (C) Patients should be formally assessed and re-assessed periodically to see if the patient is moving in a positive direction in order for the treatment to continue. (D) Supporting documentation for additional treatment must be furnished when exceptional factors or extenuating circumstances are present. (E) Evidence of objective functional improvement is essential to establish reasonableness and medical necessity of treatment. Expectation of improvement in a patient's condition should be established based on success of treatment. Continued treatment is expected to improve the

patient's condition and initiate restoration of function. If treatment does not produce the expected positive results, it is not reasonable to continue that course of treatment. In this case, there is no documentation of objective or functional improvement in this patient's condition and no evidence of a change of treatment plan to justify additional treatment in the absence of positive response to prior treatment.

It is important to mention that no treatment records were available for review during the time period immediately preceding the treatment in question. Therefore, it is not known what kinds of therapies and/or treatments had been attempted, what was beneficial and what was not, and whether the disputed treatments were different or more of the same. Without medical treatment records that answer those questions, there is less than sufficient documentation to support the medical necessity of the disputed treatment.

Prior medical records notwithstanding, the *Guidelines for Chiropractic Quality Assurance and Practice Parameters* (reference 1) Chapter 8 under "Failure to Meet Treatment/Care Objectives" states, "After a maximum of two trial therapy series of manual procedures lasting up to two weeks each (four weeks total) without significant documented improvement, manual procedures may no longer be appropriate and alternative care should be considered." According to the surgeon's report, the patient was authorized to begin rehabilitation on 11/03/03, with the four-week period thus ending well before the dates in question.

The 1996 TWCC Medical Fee Guideline provides Medicine Ground Rules on page 31. Section I, A identifies the criteria that must be met for physical medicine treatment to qualify for reimbursement: (1) the patient's condition shall have the potential for restoration of function and (2) the treatment shall be specific to the injury and provide for the potential improvement of the patient's condition. Potential for restoration of function is identified by progressive return to function. Without demonstration of objective progress, which did not occur in this case, ongoing treatment cannot be reasonably expected to restore this patient's function and thus can only be deemed medically unnecessary.

According to the Medicare Guidelines, if a patient's expected restoration potential is insignificant in relation to the extent and duration of the physical medicine services required to achieve such potential, the services are not considered reasonable or necessary. In this case, the medical records indicate that the statutory standard (reference 2) was not met, since the patient obtained no relief from the treatments, promotion of recovery was not accomplished, and there was no enhancement of the employee's ability to return to employment. In fact, the patient's lack of response was documented by the surgeon's report of 4/28/04 that indicated that the patient was in need of a chronic pain management program.

Therapeutic exercises may be performed in a clinic one-on-one, in a clinic in a group, at a gym or at home, with the least costly of these options being a home program. A home exercise program is also preferable, because the patient can perform them on a daily basis. On the most basic level, the provider has failed to establish why the services were required to be performed one-on-one.

And finally, the 7/19/04 opinion of the designated doctor (who carries presumptive weight) must be considered. His report stated that he is a fellowship trained shoulder and elbow specialist, had performed hundreds of shoulder surgeries, and authored several textbook articles on complex rotator cuff repairs. It

was his opinion that the patient exhibited, "Gross symptom magnification, self limiting behavior." He went on to opine, "Her reactivity and complaints today were not consistent with someone who is 9-1/2 months post rotator cuff repair."

Conclusion/Decision to Not Certify:

For dates of service 12/17/03 through 7/7/04, #97032-Electrical Stimulation, #99212-Office Visit, #99213-Office Visit, #99214-Office Visits, #97110-Therapeutic Exercises and #97140-Manual Therapy Technique were not medically necessary to treat this patient's injury.

References Used in Support of Decision:

1. Haldeman, S; Chapman-Smith, D; Petersen, D *Guidelines for Chiropractic Quality Assurance and Practice Parameters*, Aspen Publishers, Inc.
2. Texas Labor Code 408.021

This review was provided by a chiropractor who is licensed in Texas, certified by the National Board of Chiropractic Examiners, is a member of the American Chiropractic Association and has several years of licensing board experience. This reviewer has written numerous publications and given several presentations with their field of specialty. This reviewer has been in continuous active practice for over twenty-five years.

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