

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING
IS THE RELATED SOAH DECISION NUMBER: 453-05-4266.M5

MDR Tracking Number: M5-05-0617-01

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, 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 10-25-04.

The IRO reviewed office visits, manual therapy technique, therapeutic exercises, neuromuscular re-education and therapeutic activities rendered from 03-15-04 through 08-20-04 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.

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 11-22-04, 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 97112 (9 units) dates of service 02-20-04, 03-10-04 and 03-11-04 denied with denial code "F/435" (fee schedule MAR reduction/value of procedure is included in the value of the comprehensive procedure). The carrier made no payment. Per Rule 133.304(c) the carrier did not specify what comprehensive procedure code 97112 was included in. Per the Medicare Fee Schedule reimbursement is recommended in the amount of \$333.45 ($\$29.64 \times 125\% = \37.05×9 units).

CPT code 99080-73 date of service 03-26-04 was listed on the table of disputed services. Per the EOB provided by the respondent this service was paid in full in the amount of \$15.00 with check number 01544235 on 05-13-04. This service is no longer in dispute.

CPT code 98941 for dates of service 03-17-04, 04-02-04, 04-05-04, 04-07-04, 04-16-04, 04-28-04, 04-30-04, 05-03-04, 05-05-04, 05-10-04, 05-14-04, 05-19-04, 05-28-04, 06-07-04, 06-09-04, 06-24-04 and 07-12-04 is listed on the table of disputed services. Review of the HCFA's submitted by the requestor revealed that CPT code 98941 was not billed therefore these services are not in dispute.

CPT code 98941 date of service 04-09-04 is listed on the table of disputed services. Review of the HCFA submitted by the requestor revealed that CPT code 98941 was not billed and is therefore not in dispute.

CPT code 97530 date of service 04-09-04 is listed on the table of disputed services. Review of the HCFA submitted by the requestor revealed that CPT code 97530 was not billed and is therefore not in dispute.

CPT codes 97530 date of service 04-12-04 and codes 98941 and 97140-59 date of service 04-14-04 are listed on the table of disputed services. No HCFA's were submitted by the requestor. Per Rule 133.307(e)(2)(A) no reimbursement is recommended.

Review of CPT codes 98941, 97140-59, 97110, 97112 and 97530 date of service 05-07-04 and code 97140-59 on date of service 06-11-04 revealed that neither party submitted EOBs. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing evidence of carrier receipt of the providers request for EOBs. No reimbursement recommended.

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 dates of service 02-20-04, 03-10-04 and 03-11-04 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 20th day of January 2005.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

Enclosure: IRO Decision

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

Phone: 512-402-1400

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-05-0617-01
Name of Patient:	
Name of URA/Payer:	Laurence N. Smith, DC
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Laurence N. Smith, DC

December 10, 2004

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 Texas

Medical Foundation, 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

Medical Review of Texas (MRT) 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 MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Texas Workers Compensation Commission

CLINICAL HISTORY

Documents Reviewed Included the Following:

1. Correspondence, examination, exercise and treatment records from the provider.
2. Consultation report from James W. Galbraith, M.D.
3. Stretching sheets.
4. Left shoulder MRI report.
5. Impairment rating dated 08/25/04.

Patient underwent physical medicine treatments after injuring her neck and shoulder while lifting at work on ____.

REQUESTED SERVICE(S)

99213 office visit, 97140-59 manual therapy technique, 97110 therapeutic exercises, 97112 neuromuscular re-education, 97530 therapeutic activities from 03/15/04 through 08/20/04.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

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.

The *Guidelines for Chiropractic Quality Assurance and Practice Parameters*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." The ACOEM Guidelines² that if manipulation does not bring improvement in three to four weeks, it should be stopped and the patient reevaluated. Based on those guidelines, the 4-week time period had passed without any objective documentation of improvement so continuing the treatment was not medically necessary.

In general, most computerized documentation, regardless of the software used, fails to provide individualized information necessary for reimbursement. The Center for Medicare and Medicaid Services (CMS) has stated, "Documentation should detail the specific elements of the chiropractic service for this particular patient on this day of service. It should be clear from the documentation why the service was necessary that day. Services supported by repetitive entries lacking encounter specific information will be denied." In this case, there is insufficient documentation to support the medical necessity for

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

² ACOEM *Occupational Medicine Practice Guidelines: Evaluation and Management of Common Health Problems and Functional Recovery in Workers*, 2nd Edition, p. 299.

the treatment in question since the computer-generated daily progress notes were essentially identical for each date of service. While there are two undated examination forms, the range of motion examination performed at the termination of the disputed treatment on 08/25/04 indicates that the patient's cervical ranges of motion had not materially improved from the previous undated examinations.

In regard to the neuromuscular reeducation services (97112), there was nothing in either the diagnosis or the physical examination findings on this patient that demonstrated the type of neuropathology that would necessitate the application of this service. According to a Medicare Medical Policy Bulletin ³, "This therapeutic procedure is provided to improve balance, coordination, kinesthetic sense, posture, motor skill, and proprioception. Neuromuscular reeducation may be reasonable and necessary for impairments which affect the body's neuromuscular system (e.g., poor static or dynamic sitting/standing balance, loss of gross and fine motor coordination, hypo/hypertonicity). The documentation in the medical records must clearly identify the need for these treatments." In this case, the documentation failed to fulfill these requirements, rendering the performance of this service medically unnecessary.

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 when current medical literature states, "...there is no strong evidence for the effectiveness of supervised training as compared to home exercises." ⁴ Furthermore, the exercises contained in the submitted medical records are the exact home stretching exercises and from the same website (www.vhikits.com) that this reviewer utilizes as stretching exercise handouts for patients to do at home.

³ HGSA Medicare Medical Policy Bulletin, Physical Therapy Rehabilitation Services, original policy effective date 04/01/1993 (Y-1B)

⁴ Ostelo RW, de Vet HC, Waddell G, Kerchhoffs MR, Leffers P, van Tulder M, Rehabilitation following first-time lumbar disc surgery: a systematic review within the framework of the cochrane collaboration. Spine. 2003 Feb 1;28(3):209-18.