

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP () IE () IC	Response Timely Filed? () Yes (X) No
Requestor's Name and Address Harrison Health Institute 1916 E. Harrison, Suite 101 Harlingen, Texas 78550	MDR Tracking No.: M5-05-1549-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Texas Mutual Insurance Company Box 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
02-05-04	09-15-04	97110, 97112, 97116, 99090, 97530, 97140 and 97012	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

PART III: 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 Commission Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Medical Review Division 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 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 07-15-05, 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.

Review of CPT codes 99204, 97140, 97110, 97012, 97112, 99090, 97116 and 99214 dates of service 02-05-04, 03-16-04, 03-30-04, 04-05-04, 04-07-04, 04-15-04, 05-13-04, 05-25-04, 07-13-04, 08-30-04, 09-03-04 and 09-15-04 revealed that neither party submitted copies of 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.

CPT code 97110 (3 units) date of service 05-28-04 denied with denial code "D" (duplicate). Review of CPT code 97110 dates of service 08-12-04 and 08-19-04 revealed that neither party submitted a copy of EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for EOBs, however,

recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one". Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light of all of the Commission requirements for proper documentation. No reimbursement is recommended.

CPT code 99214 dates of service 06-15-04, 08-19-04 and 09-10-04 denied with denial code "N" (not appropriately documented). The requestor provided documentation for review that supported the services billed. Reimbursement per Rule 134.202(c)(1) is recommended in the amount of **\$290.73** ($\$77.53 \times 125\% = \$96.91 \times 3 \text{ DOS}$).

CPT code 97250 date of service 08-17-04 was listed on the table of disputed services. This is an invalid code and will not be part of the review.

PART IV: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to a refund of the paid IRO. The Division hereby **ORDERS** the insurance carrier to remit the appropriate amount for the services in dispute totaling \$290.73 consistent with the applicable fee guidelines, plus all accrued interest due at the time of payment, to the Requestor within 20-days of receipt of this Order.

Findings and Decision by:

Authorized Signature

08-09-05

Date of Decision

PART V: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____

PART VI: 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. Those who wish to appeal decisions that were issued during the month of August 2005, should be aware of changes to the appeals process which take effect September 1, 2005.

House Bill 7, recently enacted by the 79th Texas Legislature, provides that an appeal of a medical dispute resolution order that is not pending for a hearing at the State Office of Administrative Hearings (SOAH) on or before August 31, 2005 is not entitled to a SOAH hearing. This means that the usual 20-day window to appeal to SOAH, found in Commission Rule 148.3, will be shortened for some parties during this transition phase. If you wish to seek an appeal of this medical dispute resolution order to SOAH, you are encouraged to have your request for a hearing to the Commission as early as possible to allow sufficient time for the Commission to submit your request to SOAH for docketing. A request for a SOAH hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas 78744 or faxed to 512-804-4011. A copy of this Decision should be attached to the request.

Beginning September 1, 2005, appeals of medical dispute resolution 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.

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

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

Phone: 512-402-1400

FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	_____
MDR Tracking Number:	M5-05-1549-01
Name of Patient:	_____
Name of URA/Payer:	Harrison Health Institute
Name of Provider: (ER, Hospital, or Other Facility)	Harrison Health Institute
Name of Physician: (Treating or Requesting)	Christopher Henn, DC

July 28, 2005

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. Examination and treatment records from the provider
2. EOBs
3. Correspondence from the carrier
4. Designated doctor report
5. FCEs

Patient underwent physical medicine treatments, FCEs and two surgeries after sustaining a lumbar spine injury at work on ___ while working as a drilling technician.

REQUESTED SERVICE(S)

97110 therapeutic exercises; 97112 neuromuscular reeducation, 97116 gait training, 99090 analysis of clinical data, 97530 therapeutic activities, 97140 manual therapy technique, and 97012 mechanical traction (not marked as "fee") from 02/05/04 through 09/15/04.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

Based on the 07/23/04 benefit review conference where all parties agreed that the compensable injury is limited to a lumbar sprain/strain only, the medical necessity of treatment commencing 12 months after the date of injury is without any support whatsoever.

Regardless of the BRC agreement, the records failed to substantiate that the disputed services fulfilled statutory requirements¹ for medical necessity since the patient obtained little to no relief, promotion of recovery was not accomplished and there was no enhancement of the employee's ability to return to employment. The patient's pain rating was 5/10 on 02/05/04 at the initiation of treatment and remained at 4/10 on 09/16/04 after the disputed treatment ended. Moreover, all of the patient's lumbar ranges of motion (flexion, extension, left lateral and right lateral) actually decreased from the FCEs performed on 06/01/04 and 08/17/04.

Specifically regarding therapeutic exercises/activities, they 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 continuing 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." ²

¹ Texas Labor Code 408.021

² 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.

And specifically regarding 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.

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