

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP () IE () IC	Response Timely Filed? (X) Yes () No
Requestor's Name and Address South Coast Spine and rehabilitation, P.A. 620 Paredes Line Road Brownsville, Texas 78521	MDR Tracking No.: M5-05-2305-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address C/o Dean G. Pappas & Associates Box 29	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		
11-22-04	12-20-04	97124 (2 units) for dates of service 11-22-04, 11-24-04, 11-29-04, 12-02-04, 12-06-04, 12-08-04 and 12-20-04 found to be medically necessary. <u>All other dates of service were not found to be medically necessary.</u>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
12-01-04	12-30-04	97110 (2 units) for dates of service 12-01-04, 12-06-04, 12-08-04, 12-20-04, 12-22-04, 12-27-04 and 12-30-04 found to be medically necessary. <u>All other dates of service were not found to be medically necessary.</u>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
11-22-04	01-04-05	99213 for dates of service 11-22-04, 12-08-04, 12-22-04 and 01-04-05 found to be medically necessary. <u>All other dates of service were not found to be medically necessary.</u>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10-21-04	02-01-05	97113, 97032 and 97035	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
01-05-05	01-05-05	97750-FC	<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 **majority** of

medical necessity issues. The amount due from the carrier for the medical necessity issues equals **\$1,098.28**.

The requestor submitted an updated table of disputed services on 05-27-05 which is used for this review.

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 06-01-05, 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.

CPT code 97750-FC date of service 10-21-04 denied with denial code "F/N" (Fee Guideline MAR reduction/Not appropriately documented). The carrier has made a payment of \$71.40. The carrier submitted documentation for review which supported the service billed. Additional reimbursement is recommended in the amount of **\$477.40 (\$27.44 X 125% = \$34.30 X 16 units billed minus carrier payment of \$71.40)**.

Review of CPT code 97750-FC date of service 12-02-04 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for an EOB as well as a copy of the FCE report for review. Reimbursement is recommended in the amount of **\$274.40 (\$27.44 X 125% = \$34.30 X 8 units)**.

Review of CPT code 99213 dates of service 12-13-04, 12-15-04 and 12-29-04 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. Reimbursement is recommended in the amount of **\$185.94 (\$61.98 X 3 DOS)**.

Review of CPT code 97035 dates of service 12-13-04, 12-15-04 and 12-29-04 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. Reimbursement is recommended in the amount **\$44.43 (\$14.81 X 3 DOS)**.

Review of CPT code 97124 dates of service 12-13-04, 12-15-04 and 12-29-04 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. Reimbursement is recommended in the amount **\$157.68 (\$52.56 X 3 DOS)**.

Review of CPT code 97110 dates of service 12-13-04, 12-15-04 and 12-29-04 revealed that neither party submitted a copy of EOBs and date of service 12-16-04 denied with ANSI denial code W1 (Fee Schedule Adjustment). 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 all of the Commission requirements for proper documentation. Reimbursement not recommended.

CPT code 97035 date of service 12-16-04 denied with ANSI code W1 (Fee Schedule Adjustment). The carrier has made no payment. Reimbursement is recommended in the amount of **\$14.81**.

CPT code 97124 (2 units) date of service 12-16-04 denied with ANSI code W1 (Fee Schedule Adjustment). The carrier has made no payment. Reimbursement is recommended in the amount of **\$52.56**.

Review of CPT code 99080-73 date of service 01-18-05 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. Reimbursement is recommended in the amount **\$15.00** per Rule 129.5.

CPT code 99080 date of service 02-01-05 denied with denial code 0798 (does not fall within the guidelines of a reimbursable report per the state's guidelines). The billed service was for 96 pages of records (per HCFA). The carrier has not made a payment. Reimbursement is recommended in the amount of **\$48.00**.

PART IV: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to reimbursement in the amount of \$2,368.50 for services involved in this dispute. The requestor is not entitled to a refund of the paid IRO fee. The Division hereby **ORDERS** the insurance carrier to remit the appropriate amount for the services in dispute 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 and Order by:

Authorized Signature

07-22-05

Date of Decision and Order

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

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a 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.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

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

REVISED 7/20/05

TWCC Case Number:	
MDR Tracking Number:	M5-05-2305-01
Name of Patient:	
Name of URA/Payer:	South Coast Spine & Rehabilitation
Name of Provider: (ER, Hospital, or Other Facility)	South Coast Spine & Rehabilitation
Name of Physician: (Treating or Requesting)	Robert S. Howell, DC

July 5, 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

Available documentation received and included for review consists of records from Drs Kramer (MD) Tijmes (MD), initial and subsequent reports with treatment records from Dr. Howell, FCE's , MRI and X-ray reports. Peer reviews are also enclosed.

Mr. ____, a 53-year-old male, was involved in a work-related automobile accident on ____ while employed with _____, resulting in injuries to his neck. He was a restrained, front passenger in a Chevy truck that was rear-ended by a Ford Mustang. He presented the next day to Dr. Howell, a chiropractor, complaining of a 5/10 level of pain to his neck and shoulders along with some headaches. Dr. Howell's impression was of cervical and shoulder sprain/strain injuries and he proceeded to place the patient on a conservative treatment regime consisting of ultrasound, interferential, massage and aquatic therapy until 12/01/04, when treatment progressed to include active exercises instead of aquatic exercises. The patient was taken off work until 01/19/05. An initial FCE was performed on 10/21/04 with the patient qualifying for light work category, capacities included a 16lb frequent waist to and 19 lb above shoulder lifting ability.

A second functional capacity evaluation was performed 12/2/04 and this demonstrates improvement in strength and range of motion to a medium PDL. There were no further shoulder complaints documented. Visual analog scale readings by 11/24/04 were 2/10 with minimal, intermittent pain. By 12/30/04 pain level was 1/10. On 1/4/05, the patient's diagnosis was changed to cervical and thoracic HNP. An evaluation 1/5/05 reported no functional limitations while performing ADLs.

A pain management referral was made to Dr. Kramer on 10/26/04, complaints were persistent neck pain. Cervical and thoracic spine areas were noted to be supple without tenderness to palpation or trigger points with full range of motion. Shoulder exam was normal,

full pain-free range of motion also. Assessment was of cervical facet arthropathy and thoracic strain. Recommendations were for MRI of the cervical and thoracic spine. Assessment included "patient shows cyclic

musculoskeletal deconditioning which is contributing to a cycle of chronic pain and dependency on analgesic medications". MRI was obtained on 11/2/04 and revealed multilevel central canal stenosis, with degenerative chronic spondylitic protrusions mildly effacing the ventral thecal sac, neural foraminal stenosis and a small protrusion at C4-5 C5. In the thoracic spine and a small 3 mm disc protrusion was noted to T5/T6 along with mild spondylosis.

Follow-up with Dr. Kramer on 11/16/04 reported 5/10 neck pain centralized on the posterior aspect with pain looking up and turning to the left right. Tightness across the upper shoulder/posterior trapezius area. This time exam showed significant pain with palpation of the posterior and neck of the C3/C4 C5/C6 facet joints with pain on extension rotation. Shoulder exam was again normal. Recommendation was for facet joint injections.

Patient had an orthopedic consult with Dr. Timines on 11/5/04. Complaints were of cervical pain with radiation into the upper back and down the posterior aspect of both shoulders. Exam revealed paravertebral spasms to the neck bilaterally, with slight increased cervical range of motion. Neurologically the patient was intact. Normal upper extremities and bilaterally. Impression was neck pain with cervical HNP. Recommendation was for neurological consult with EMG/NCV studies to rule out radiculopathy, along with referral to a pain clinic for cervical ESI.

Follow-up with Dr. Kramer on 12/21/04 revealed the patient requested to go back to work saying that he should be able to return to light duty. Otherwise the report was identical to that of 11/16/04. Follow-up on 1/18/05 showed patient complaining of 0/10 pain, no complaints or pain, wishing to be discharged and returned to work.

Follow up with Dr. Timines on 1/10/05 reports moderate cervical pain radiating to the upper back and down both arms. Apparently Dr. Kramer had performed some cervical injections. Exam reveals mild simple paravertebral spasms, normal range of motion with mild discomfort. EMG/NCV performed 2/9/05 (Dr. Mirles) was normal.

REQUESTED SERVICE(S)

Medical necessity of office visits (99213) electrical stimulation-manual (97032), massage therapy (97124), therapeutic exercises (97110), aquatic therapy (97113), ultrasound (97035), functional capacity evaluation (97750). Service dates 11/22/04-1/5/05.

DECISION

Approve 2 units of massage therapy (97124) on 11/22/04, 11/24/04, 11/29/04, 12/2/04, 12/6/04, 12/8/04 and 12/20/04 dates of service only. There is no medical necessity established for this procedure on any other dates of service.

Approve 2 units of therapeutic exercises (97110) on 12/1/04, 12/6/04, 12/8/04, 12/20/04, 12/22/04, 12/27/04 and 12/30/04. There is no medical necessity established for this procedure on any other dates of service.

Approve office visits (99213) on 11/22/04, 12/8/04, 12/22/04 and 1/4/05. There is no medical necessity established for this procedure on any other dates of service.

Deny aquatic therapy (97113) for any of the disputed dates of service.

Deny attended electrical stimulation (97032) for any of the disputed dates of service.

Deny ultrasound (97035) for any of the disputed dates of service.

Deny functional capacity evaluation 97750-FC on 1/5/05.

RATIONALE/BASIS FOR DECISION

The standard of medical necessity in Workers Comp, according to the Texas labor code 408.021 (entitlement to medical benefits) is that an employee who sustained a compensable injury is entitled to all healthcare reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to healthcare that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment.

There is no rationale offered for the on-going requirement for attended electrical stimulation or ultrasound. These are passive modalities usually

incorporated/utilized within the first four to six weeks of an acute injury, in an attempt to 'activate' a patient by providing analgesic effects in combination with anti-inflammatory / muscle relaxing properties. There is no rationale supplied as to why such attended applications were required, especially with a pain level of 2-3/10 as reported by 11/22/04, with minimal objective reports of deficit. The patient had already undergone multiple visits prior to 11/22/04, including the 1-1.5 hours of aquatic therapy. There is no clinical rationale or indication presented for continuing these passive modalities in such an on-going fashion.

There is not sufficient documentation as to why this patient was ever placed on an aquatic therapy program. By all accounts, he had suffered a relatively uncomplicated cervical sprain/strain injury. There is no clinical evidence supported as to any shoulder injury, and no shoulder injury / complaints were established by either of the two consulting physicians (evaluation as early as 10/24/05 showed the shoulder exam to be "normal"). The posterior shoulder girdle pain was most likely part of the cervicothoracic injury. I'm aware of no guidelines that support an aquatic-based program for such a simple cervicothoracic injury. Aquatic based programs are usually reserved for an initial, early activation stage in the progressive rehabilitation of patient's intolerant of land based exercises. There is no evidence supplied as to why this patient was intolerant of a regular, land-based program.

Although the patient had 2/10 with 'minimal, intermittent pain complaints, who there is sufficient clinical justification to allow for further four weeks of massage therapy, supported by contemporary treatment guidelines. There is insufficient evidence provided as to why sequential daily visits were required, however.

Likewise, there is sufficient evidence to suggest that land based exercises may have been appropriate for the dates of service outlined above. For such a focused problem, with a low pain threshold, and I do not find any evidence for more than two units of exercises per encounter date. There is no clinical evidence established at any treatment should continue beyond 12/30/04.

With respect to the office visits, the documentation again supports a fairly uncomplicated cervical sprain/strain injury. The patient was placed on an extensive treatment regime consisting of multiple visits. There is no clinical rationale for the necessity of evaluation and management services on each encounter date. Periodic monitoring

every two weeks should have been more than sufficient for such an uncomplicated issue.

Regarding the functional capacity evaluation, the patient had himself requested a return to work as early as 12/21/04. The patient qualified for light duty by the time of his first FCE evaluation and for medium duty by 12/2/04. I do not understand why this patient was not returned to a work environment very much earlier and to see no reason for yet another functional capacity evaluation as late as 1/4/05.

The above analysis is based solely upon the medical records/tests submitted. It is assumed that the material provided is correct and complete in nature. If more information becomes available at a later date, an additional report may be requested. Such and may or may not change the opinions rendered in this evaluation.

Opinions are based upon a reasonable degree of medical/chiropractic probability and are totally independent of the requesting client.

References:

Hansen DT: Topics in Clinical Chiropractic, 1994, volume one, No. 4, December 1994, pp. 1-8 with the article "Back to Basics: Determining how much care to give and reporting patient progress".

Haldeman S., Chapman-Smith D, Peterson DM., eds. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen: Giathersburg, MD, 1993;

Souza T: Differential Diagnosis for a Chiropractor: Protocols and Algorithms, 1997; chapter 1, pp. 3-25.

Liebenson C. Commentary: Rehabilitation and chiropractic practice. JMPT 1996; 19(2):134140