

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 Jupiter Health Works, Inc 13567 Jupiter Road # 106 Dallas, Texas 75238	MDR Tracking No.: M5-05-2349-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Royal Indemnity Company Box 11	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		
05-24-04	06-07-04	97110 (3 units), 97032 (paid by respondent),	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
05-17-04	05-17-04	97010 (no reimbursement calculated in total due from carrier as code is global per Medicare)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input 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 the disputed medical necessity issues. The amount due from the carrier for the medical necessity issues equals **\$554.85**.

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 05-24-05, 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 99358-52 dates of service 05-24-04 and 06-28-04 denied with denial code "V" (unnecessary medical treatment with peer review). This code with modifier 52 is invalid. No reimbursement recommended.

CPT code 99080-73 date of service 06-25-04 denied with denial code "V" (unnecessary medical treatment with peer review). The TWCC-73 per Rule 129.5 is a required report and is not subject to an IRO review. Reimbursement is

recommended in the amount of **\$15.00**. A Compliance and Practices referral will be made as the carrier is in violation of Rule 129.5.

PART IV: COMMISSION DECISION AND ORDER

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 fee. The Division hereby **ORDERS** the insurance carrier to remit the appropriate amount for the services in dispute totaling \$569.85 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.

Ordered by:

Authorized Signature

Typed Name

06-10-05

Date of 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

TWCC Case Number:	
MDR Tracking Number:	M5-05-2349-01
Name of Patient: _____	
Name of URA/Payer:	Jupiter Health Works
Name of Provider: (ER, Hospital, or Other Facility)	Jupiter Health Works
Name of Physician: (Treating or Requesting)	Mark Laning, DC

June 6, 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

Items Reviewed:

1. Notification of IRO Assignment, Table of Disputed Services, Carrier EOBs, copies of treating doctor's CMS 1500 forms
2. Request for reconsideration letter from treating doctor, dated 3/9/05
3. Treating doctor's initial examination, dated 2/15/02
4. Treating doctor's narrative notes, multiple dates
5. MRI report of left and right knees, dated 8/19/02
6. Contested case hearing Decision and Order on Remand, dated 5/19/03
7. Designated doctor report and TWCC-69, dated 12/7/03
8. Short term disability/medical leave application, dated 2/24/04
9. Functional Capacity Evaluation, dated 7/8/04
10. Treating doctor-selected TWCC-69, dated 7/9/04
11. Peer review, dated 4/20/04
12. Treating doctor's "S.O.A.P." notes and therapy notes from 5/17/04 through 6/28/04, and also from multiple other dates
13. Multiple TWCC-73s

Patient is a 27-year-old male who worked in shipping and receiving for a major bank and was on his feet for prolonged periods of time. On ____, he was pushing a cart full of checks and bank statements in trays that weighed over 100 pounds and it was somewhat difficult to push and maneuver. He reportedly turned a corner and in doing so, he twisted his legs and injured both knees. He was seen first in the emergency room, his knees were x-rayed, and he was released. (Later, following a contested case hearing, it was determined that the injury was due to repetitive trauma versus a single event on _____. As a result, the date of injured was amended back to _____.) He followed up with Concentra and received physical therapy through 2/4/02. He was

returned to work full-duty on 1/11/02 but this apparently aggravated his condition, so he was placed on work restrictions on 1/16/02. On 2/15/02, he began treating with a doctor of chiropractic and received active and passive physical therapy modalities. MRI studies were eventually performed that revealed a horizontal posterior medial meniscal tear of the right knee, and a "focal abnormality" of the anterior cruciate ligament suggesting a small avulsion with mild medial collateral ligamentous thickening of the left knee. Right knee arthroscopic repair was finally performed on 1/27/04, followed by post-operative physical therapy and rehabilitation, and his left knee surgery was on 5/4/04.

REQUESTED SERVICE(S)

Electrical stimulation, attended (97032), hot/cold packs (97010), analysis of clinical data (99090), gait training (97116), neuromuscular reeducation (97112), and therapeutic exercises (97110) for dates of service 5/17/04 through 6/28/04.

DECISION

The attended electrical stimulation (97032) and the hot/cold packs (97010) are approved. In addition, up to a maximum of three units of therapeutic exercises (97110) per patient encounter are approved.

All remaining treatments and procedures, including all therapeutic exercise units reported in excess of 3 per encounter are denied.

RATIONALE/BASIS FOR DECISION

In this case, the medical records adequately documented that a compensable injury to the patient's knees had occurred and that both eventually required surgical intervention, the second one occurring on _____. Therefore, it was both reasonable and medically necessary that the patient received a regimen of post-operative physical therapy and rehabilitation to include passive and active care (97032 and 97110) through the dates in dispute.

However, due to the areas of involvement as well as the specific diagnoses, the medical records failed to support the medical necessity and rationale for supervised therapeutic exercises in excess of 45 minutes.

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 Bulletin¹, "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.

Furthermore, with regard to the gait training (97116) services, the medical records were also absent of any documentation to support the medical necessity for the performance of this service. In fact, the treating doctor's subsequent medical report dated 5/13/04 – immediately before these dates of service in dispute began – stated, "His gait is unremarkable." Therefore, gait training services and procedures were also not supported as medically necessary.

And finally, insofar as the analysis of clinical data (99090) services was concerned, no documentation whatsoever was supplied to even indicate exactly what was reviewed or why the review was necessary. Therefore, absent this clinical documentation, the medical necessity for the performance of this service was not supported.

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