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 (X) No
Requestor's Name and Address **Cotton D. Merritt, D. C.** **2005 Broadway** **Lubbock, TX 79401**	MDR Tracking No.: M5-05-2354-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address **Liberty Mutual Fire Insurance, Box 28**	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS – MEDICAL NECESSITY ISSUES

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	**To**		
5-21-04	**7-13-04**	**4 units of CPT code 97110**	☒ **Yes** ☐ **No**
5-21-04	**7-13-04**	**more than 4 units of CPT code 97110, CPT codes 99212-25, 97112, 97140,**	☐ **Yes** ☒ **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 total owed the requestor for the medical necessity services is $1,791.92.

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 fee**.** The Division hereby **ORDERS** the insurance carrier to remit the appropriate amount for the services in dispute consistent with the applicable fee guidelines totaling $1,791.92, 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:

	Donna Auby	8-3-05
Authorized Signature	Typed Name	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

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.

July 29, 2005

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution

MDR #:	M5-05-2354-01
TWCC#:	
Injured Employee:	___
DOI:	___
SS#:	
IRO Certificate No.:	IRO 5055

Dear ___:

IRI has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc. and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is licensed in chiropractic, and is currently on the TWCC Approved Doctor List.

Sincerely,

Gilbert Prud'homme
General Counsel

GP:thh

REVIEWER'S REPORT
M5-05-2354-01

Information Provided for Review:
TWCC-60, Table of Disputed Services, EOB's
Information provided by Requestor:
- Letter of medical necessity
- Office notes 04/21/04 – 03/21/05
- Physical therapy notes 04/22/04 – 02/17/05
- Nerve conduction study 05/19/04
- Operative report 06/08/04
- Radiology report 02/02/04 – 05/13/04

Information provided by Respondent:
- Designated reviews

Information provided Spine Surgeon:
- Office notes 07/21/04 – 10/28/04

Information provided Sports Medicine Specialist:
- Office notes 05/10/04 – 08/05/04

ER reports 02/02/04 – 04/07/04

Clinical History:

This 46-year-old male patient injured his right shoulder and arm in a work-related accident on ___. He was seen a couple of days later at the emergency room where x-rays were negative for fracture and Venous ultrasound was negative for thrombosis, and he was diagnoses with contusion.

When his pain persisted, he presented to a doctor of chiropractic on 4/20/04 who began physical therapy and rehabilitation. He was referred for a shoulder MRI on 3/9/04, which revealed arthritic changes and spurring within the AC joint, but no evidence of either bursitis or rotator cuff tear. When the patient's response was still less than expected, the patient was referred to an orthopedic specialist who ordered a cervical MRI and upper extremity EMG/NCV. The findings revealed disc protrusions and right-sided neuroforaminal compromise at C5-6 and C6-7 with essentially unremarkable electrodiagnostic testing.

Cervical epidural steroid injections were then attempted, along with post-injection physical therapy and rehabilitation, and yet the patient still had to undergo a two-level ACDF that was performed on 8/28/04, followed by post-surgical rehabilitation, and on 2/17/05, was released to a "self care program.

Disputed Services:
Office visits, therapeutic exercises, neuromuscular re-education, manual therapy technique during the period of 05/21/04 thru 07/13/04

Decision:
The reviewer partially disagrees with the determination of the insurance carrier and is of the opinion that a total of four (4) units of therapeutic exercises (97110) per patient encounter were medically necessary. All other services and procedures in dispute, including all other units of therapeutic exercises in excess of 4 units per encounter, were not medically necessary in this case.

Rationale:
In this case, the records adequately documented that a compensable injury occurred to the patient's neck and right shoulder. 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."

Upon careful review of the documentation submitted, the daily treatment notes revealed that at eight weeks from the initial examination (or, on date of service 6/14/04), both the patient's strength and active range of motion had improved. Therefore, not only had the treatment rendered to that point been medically necessary, the "significant documented improvement" supported the medical necessity of continued utilization of manual procedures. But, due to the areas of injury, no more than 4 units per encounter were supported as medically necessary.

In terms of the established patient office visits, level II (99212), according to CPT2, nothing in either the diagnosis or medical records in this case supported the medical necessity of performing this level of an Evaluation and Management (E/M) service on each and every patient encounter, and particularly not during an already-established treatment plan. In addition, 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 was insufficient documentation to support the medical necessity for repetitive E/M services since the daily progress notes were essentially identical for each date of service.

Regarding manual therapy techniques (97140), the medical records were unclear regarding precisely what was performed under the umbrella of services represented by this code. According to CPT, this service is used to report manual traction, joint mobilization, myofascial release, or a number of other services. Therefore, not only is it incumbent upon the provider to specify which specific service was performed when this code is reported, it is also important to indicate *where* it was performed. Simply stating "…and joint mobilization and myofascial release," fails to meet this requirement and the medical necessity of the service cannot be supported.

And finally, with regard to the reported neuromuscular reeducation services (97112), there was nothing in either the diagnosis or

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1 Haldeman, S; Chapman-Smith, D; Petersen, D *Guidelines for Chiropractic Quality Assurance and Practice Parameters,* Aspen Publishers, Inc.
2 *CPT 2004: Physician's Current Procedural Terminology, Fourth Edition, Revised*. (American Medical Association, Chicago, IL 1999),

the physical examination findings on this patient that demonstrated the type of neuropathology that would necessitate the application of this service, particularly with "…no evidence of other entrapment, neuropathy or radiculopathy in the bilateral upper extremities…" (EMG/NCV report dated 5/19/04). 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)