

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## Retrospective Medical Necessity Dispute

### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (X) HCP ( ) IE ( ) IC	<b>Response Timely Filed?</b> (X) Yes ( ) No
Requestor's Name and Address Allied Multicare Centers 415 Lake Air Drive Waco, Texas 76710	MDR Tracking No.: M5-05-2391-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address  Continental Casualty Company, Box 47	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		
4-28-04	1-12-05	CPT code 97110, 97112, 98941, 97124, 97530, 98943, 99213, 98940, 95831, 97012, 99212, G0283, 97024, 95904, 95900, 95935, 95937	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
			<input type="checkbox"/> Yes <input checked="" 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 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 6-8-05 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 97124 on 1-3-05 was denied as "G-Bundling". This code is considered by Medicare to be a component procedure of CPT code 98940 which was billed on this date. No reimbursement recommended.

**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 reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

7-6-05

\_\_\_\_\_  
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**

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:	M5-05-2391-01
Name of Patient:	
Name of URA/Payer:	Allied Multicare Centers
Name of Provider: (ER, Hospital, or Other Facility)	Allied Multicare Centers
Name of Physician: (Treating or Requesting)	Ronald D. Linderman, DC

June 29, 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. Narratives, examination and treatment records from the provider.
2. EOBs
3. Diagnostic imaging report
4. Designated doctor report
5. Electrodiagnostic testing reports
6. Carrier peer reviews
7. Correspondence from carrier attorney

Claimant underwent examinations and physical medicine treatments after injuring her lumbar spine on \_\_\_\_ when she fell to the floor after a co-worker pulled her chair away as she was preparing to sit down.

### REQUESTED SERVICE(S)

97110 Therapeutic exercises, 97112 neuromuscular re-education, 98941 CMT spinal, 97124 massage therapy, 97530 therapeutic activities, 98943 CMT extraspinal, 99213 office visits, 98940 CMT, 95831 Muscle Testing-Extremity, 97012 Mechanical traction, 99212 office visits, G0283 Electrical stimulation, 97024 diathermy, 95904 Nerve conduction, 95900 nerve conduction – no F wave, 95935 H or F reflex study, 95937 neuromuscular junction testing (mark with "V" codes) from 04/28/04 through 01/12/05.

### DECISION

Denied.

### RATIONALE/BASIS FOR DECISION

Physical medicine is an accepted part of a rehabilitation program following an injury. However, for medical necessity to be established there must be an expectation of recovery or improvement within a reasonable and generally predictable time period. In addition, the frequency, type and duration of services must be reasonable and consistent with the standards of the health care community. General expectations include: (A) As time progresses, there should be an increase in the active regimen of care, a decrease in the passive regimen of care and a decline in the frequency of care. (B) Home care programs should be initiated near the beginning of care, include ongoing assessments of compliance and result in fading treatment frequency. (C) Patients should be formally assessed and re-assessed periodically to see if the patient is moving in a positive direction in order for the treatment to continue. (D) Supporting documentation for additional treatment must be furnished when exceptional factors or extenuating circumstances are present. (E) Evidence of objective functional improvement is essential to establish reasonableness and medical necessity of treatment. 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, the medical records substantiate that the disputed treatment did not fulfill statutory requirements 1 for medical necessity since the patient obtained no pain relief, promotion of recovery was not accomplished and there was no enhancement of the employee's ability to return to or retain employment. Specifically, the patient's pain rating was 4-5/10 on 03/04/04 before the initiation of the disputed treatment and was 4/10 on 01/12/04 at the conclusion of the disputed treatment. The patient's non-response to care is also documented by the provider's daily "subjective" notes that repeatedly state, "...same as the last visit."

Moreover, the previously attempted therapy had been unsuccessful as evidenced by the patient's left lateral bending and right lateral bending lumbar ranges of motion that actually decreased from 03/04/04 to 04/15/04. Therefore, the provider should have foreseen that the patient was unlikely to benefit in any meaningful way from repeating past unsuccessful treatments. Therefore, the disputed treatment was not indicated or medically necessary.

And finally, 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, the computer generated treatment notes failed to support the medical necessity for the treatment in question.