

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 Dr. Marsha Miller 2306 S. Buckner Dallas, TX 75227	MDR Tracking No.: M5-05-2437-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address American Home Assurance Company, Box 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

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

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
10-21-04	2-01-05	CPT codes 98941, 97110, 97110-59, 97150, 97150-59	<input checked="" 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 **prevailed** on the disputed medical necessity issues. The amount due the requestor for the medical necessity issues totals \$2,056.43.

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. The services, rendered were found were not found to be medically necessary. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 6-24-05 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.

1 unit of CPT code 97110 on 12-1-04 was denied as "F – Fee Schedule MAR Reduction." 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. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. 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. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy.

Reimbursement not recommended.

CPT code 97012 on 10-21-04 was denied as “N – Not documented.” The requestor did not provide documentation to support delivery of services per Rule 133.307(g)(3)(A-F). **Recommend no reimbursement.**

CPT code 97022 on 10-28-04 was denied as “N – Not documented.” The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). **Recommend reimbursement of \$19.41.**

CPT code 97010 (hot/cold pack application) on 10-28-04 is a bundled service code and considered an integral part of a therapeutic procedure(s). Therefore, per the 2002 Medical Fee Guideline, **no reimbursement is recommended.**

Regarding CPT code 99358-52 on 10-29-04 (2 units) and 2-1-05: Per the Medicare Fee Schedule “52” is not a valid modifier. This service will not be a part of this review.

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 entitled to a refund of the paid IRO fee in the amount of \$460.00. The Division hereby **ORDERS** the insurance carrier to remit the amount of \$2,075.84, plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Donna Auby

7-25-05

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 en 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:	M5-05-2437-01
Name of Patient:	_____
Name of URA/Payer:	Marsha Miller, DC
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Marsha Miller, DC

July 18, 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 initial and subsequent reports and treatment records from Drs Miller (DC) and Kilgore (DC); consults from Drs Cunningham and Henderson (MD); MRI, electrodiagnostic and X-ray reports. Retrospective reviews performed by Dr.'s Osborne (MD), Hayes (DC) Hamby. (DC) Enkvetchakul (MD).

Mr. ____, a 38-year-old male, was involved in a work-related injury whereby he some shelves fell on him, striking him in the head and knocking him backwards. He developed neck, low back and right shoulder pain. He presented to the doctors Hospital where he was x-rayed and prescribed pain medication. He subsequently reported to Dr. Miller on 10/11/04. Further x-rays ordered, along with MRI of the neck, low back and shoulder on 10/25/04, spinal and extremity diagnostic ultrasounds, the lumbar MRI revealed a 4-5 mm poster central protrusion at L5/S1, which minimally indents at the thecal sac the cervical MRI revealed a 5-6 mm right lateral recess disc protrusion which moderately indents of the spinal cord at C5-6, and a 5 mm right poster central protrusion at C6/7 in Denton the spinal

cord a moderate to severe degree resulting in a moderate degree of central spinal canal stenosis. The MRI of the right shoulder was normal. The spinal ultrasounds apparently revealed a normal thoracic spine, with a facet joint inflammation in the cervical, lumbar and sacroiliac joints. The electrodiagnostic studies were all within normal limits.

Dr. Miller who placed the patient on a comprehensive conservative treatment regime consisting of manipulation with adjunctive physiotherapeutic modalities progressing to more active interventions. A second orthopedic opinion was obtained from Dr. Cunningham on 12/7/04 complaining of minimal axial neck pain. A CT myelogram was recommended and this revealed ventral compression of the thecal sac at C5/6 with amputation of both C6 nerve roots, right greater than left. Mild ventral ridging of the thecal sac at C6-C7 with right greater than left compression of the C7 nerve roots. Follow-up with another orthopedist, Dr. Henderson on 1/28/05 indicates head, right shoulder and right arm symptomatology all resolved. Intermittent 3/10 level low back pain aggravated by driving. The patient indicated that he wished to return to work and Dr. Henderson felt that he could do so on an unrestricted basis. Patient followed up on 2/2/05 Dr. Cunningham who confirmed right arm radiculopathy completely resolved. He felt that he had nothing further to offer patient unless symptoms significantly worsened at which time he would have to consider surgery. At this point the patient reported that he was completely asymptomatic and declined any surgical recommendation.

REQUESTED SERVICE(S)

Medical necessity of chiropractic manipulation (98941), therapeutic exercises (97110, 97110-59), group therapeutic activities (97150, 97150-59); service dates 10/21/04 - 2/1/05.

DECISION

Approved.

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.

The initial evaluation and subsequent treatment notes substantiate cervical spine, right shoulder and lumbar spine injury. The patient additionally had signs and symptoms of radiculopathy. Subsequent improvement was obtained with treatment rendered., which, by the beginning of February 2005, had resolved the complaints.

Current clinical guidelines for standard of care support a trial period of spinal manipulation with adjunctive procedures as being appropriate (Hansen DT: Topics in Clinical Chiropractic, / The U.S. Department of Health and Human Services Agency For Health-Care Policy and Research (AHCPR), publication No. 95-0643 entitled Acute Low Back Problems in Adults: Assessment and Treatment, / Haldeman S., Chapman-Smith D, Peterson DM., eds. Guidelines for Chiropractic Quality Assurance and Practice Parameters, / Shekelle PG, Adams AH, Chassin MR, et al: The Appropriateness of Spinal Manipulation for Low Back Pain, Indications and Ratings of a Multidisciplinary Expert Panel, / Souza T: Differential Diagnosis for a Chiropractor: Protocols and Algorithms, Official Disability Guidelines)

The guidelines are generally in agreement that initial trial period of manual therapy consists of up to two weeks at a visit frequency of 3-5 visits per week (as appropriate), with appropriate tapering of care and transition to a more active mode of care, eliminating passive modalities, followed by a re-evaluation. If, at that time, there is not a significant documented improvement, a second course of two weeks of care, utilizing different types of manual procedures is appropriate. In the absence of documented improvement, manual procedures are no longer indicated after four weeks. If a patient does not have signs of objective improvement in any two successive two-week periods, referral is indicated¹. Contemporary treatment guidelines generally agree with the Mercy document that all episodes of symptoms that remain unchanged for 2-3 weeks should be evaluated for risk factors of pending chronicity, with treatment plans altered to de-emphasize passive care and refocus on active care approaches.

In the situation, there is sufficient evidence to show that this case showed significant factors for complexity requiring extended trial periods of care. Functional improvement was obtained and demonstrated with treatment in the disputed time frame.

As such, the treatment rendered satisfies the above-mentioned standard for medical necessity according to the Texas labor code, and are within accepted clinical practice guidelines.

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