Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity and Fee Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address: Park Cities Spine and Sports Center P.O. Box 549 Dallas, TX 75238	MDR Tracking No.: M5-05-2476-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Transcontinental Insurance Company, Box 47	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents submitted included TWCC 60 form, Explanations of Benefits and CMS 1500's.
The position paper states, "Necessary Medical Treatment."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents submitted included TWCC 60 form, Explanations of Benefits, CMS 1500's and medical documents.
The position paper states, "A the requestor has failed to establish the necessity for their excessive chiropractic treatments, no reimbursement is warranted."

PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
8-9-04 – 11-18-04	97110, 97140-59, 97112	☐ Yes ☒ No	-0-

PART V: 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 Division Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), Medical Dispute Resolution 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.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision:

	Donna Auby	9-20-05
Authorized Signature	Typed Name	Date

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and 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. The Division is not considered a party to the appeal.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

September 7, 2005

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

Re: Medical Dispute Resolution

MDR #:	M5-05-2476-01
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:dd

REVIEWER'S REPORT
M5-05-2476-01
___

Information Provided for Review:
TWCC-60, Table of Disputed Services, EOB's
Information provided by Requestor:
- PT Notes 08/09/04 – 11/18/04
- Functional Capacity Eval 10/12/04
- Electrodiagnostic Study 08/20/02

Information provided by Respondent:
- Correspondence
- Designated Reivew

Neuro-Surgeon
- Office Notes 02/23/04 – 08/31/04
- OR Report 10/29/02 – 06/10/04

Clinical History:

Patient is a 58-year-old male roofer who, on ___, was using a pulley and a rope to lift a heavy load of rolls (weighing an estimated 100 pounds) 20 feet into the air when he began experiencing pain in his right medial elbow that radiated into his forearm. There was no direct blow or trauma to the extremity. The patient was initially seen at Concentra, prescribed medications, injections, rest and physical therapy. Initial NCV/EMG testing revealed severe cubital tunnel syndrome, so a release procedure was first performed on 10/29/02, followed-by post-surgical physical therapy and rehabilitation. On 3/28/03, the patient was seen by a designated doctor and determined to be at MMI with an18% whole-person impairment.

After several unsuccessful attempts over a 6-week period, a TWCC-53 (Change of Treating Doctor) was finally approved on 11/25/03, and the patient began his ongoing care under the supervision of a doctor of chiropractic. Additional testing and conservative treatment ensued, including mental health evaluations, but despite this, the patient underwent a second surgical procedure on 6/10/04, specifically a decompression with external neurolysis and transposition of the ulnar nerve, followed by additional post-surgical physical therapy and rehabilitation.

Disputed Services:
Therapeutic exercises (97110), manual therapy techniques (97140-59), and neuromuscular reeducation (97112) for dates of service 8/9/04 through 11/18/04.

Decision:
The reviewer agrees with the determination of the insurance carrier and is of the opinion that the services in dispute as stated above were not medically necessary.

Rationale:
Therapeutic exercises (97110) may be performed in a clinic one-on-one, in a clinic in a group, at a gym, or at home with the least costly of these options being a home program. A home exercise program is also preferable because the patient can perform them on a daily basis, and indeed, the treating doctor's medical records indicated that the patient was participating successfully in a home program during this time frame. In fact, date of service 10/28/04 stated in its record, "The claimant states that his condition is improving and that he is not experiencing any problems with his home rehabilitation exercise program, and is performing 7 sets of 10 minutes each day and is encouraged to remain compliant with reported frequency/duration."

Therefore, on the most basic level, the provider failed to adequately establish why it was necessary to continue providing supervised, one-on-one therapeutic exercises on this patient in addition to the documented successful home program, particularly when the records revealed that he was safely and successfully participating in a home program. This is further challenged when current medical literature states, "…there is no strong evidence for the effectiveness of supervised training as compared to home exercises."1 Any gains obtained in this time period would have likely been achieved through performance of a home program alone.

With 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 Bulletin 2, "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.

And finally, insofar as the manual therapy techniques (97140-59) were concerned, the documentation submitted failed to demonstrate that this treatment rendered any benefit. Specifically, the daily record for date of service 8/25/04 (near the beginning of the dates in dispute) stated, "The claimant presents with pain intensity 3-5/10 on VAS and paresthesia intensity of 6-7/10 on VAS over the right cubital tunnel and volar/dorsal aspect of the right upper quarter. The worker continues to state that he experiences constant numbness/paresthesia into the $4^{th}/5^{th}$ digits of the right upper quarter…"

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1 Ostelo RW, de Vet HC, Waddell G, Kerchhoffs MR, Leffers P, van Tulder M, Rehabilitation following first-time lumbar disc surgery: a systematic review within the framework of the cochrane collaboration. Spine. 2003 Feb 1;28(3):209-18.
2 HGSA Medicare Medical Policy Bulletin, Physical Therapy Rehabilitation Services, original policy effective date 04/01/1993 (Y-1B)

And, the daily record for the last date of service in dispute (11/18/04) stated, "[The patient] presents with pain intensity of 3-4/10 on VAS localized over the right cubital tunnel region with radiation of pain/paresthesia/burning/sharp sensations into the volar/dorsal aspect of the 4th/5th digits of the right upper quarter. The claimant states that the paresthesia/burning sensations over the right upper quarter are experienced on a near constant basis." A full 2½ months of treatment later and the presentation of the patient had remained essentially the same.

The *Guidelines for Chiropractic Quality Assurance and Practice Parameters* 3 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." By the initial date in dispute here (8/9/04), the post-surgical manual procedures (97140-59) had already been utilized for 8 weeks total, and no "significant documented improvement" occurred as a result of care rendered past this time frame. Therefore, the care in question failed to meet the statutory requirements4 for medical necessity, as no relief was obtained, recovery was not enhanced, and (since the records also indicated that the patient remained off work during this time) a return to employment was not achieved.

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3 Haldeman, S; Chapman-Smith, D; Petersen, D *Guidelines for Chiropractic Quality Assurance and Practice Parameters,* Aspen Publishers, Inc.

4 Texas Labor Code 408.021