

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
Requestors Name and Address Horizon Health % Bose Consulting, L. L. C. P. O. Box 550496 Houston, Texas 77255	MDR Tracking No.: M5-05-2498-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address City of Houston, Box 42	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		
4-12-04	12-22-04	CPT codes 97110, 99212, 99213 (except as listed below), 97112, 97140	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
6-7-03	6-7-03	CPT code 99213	<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 did **not** prevail on the majority of the disputed medical necessity issues. **The total amount due the requestor for the medical necessity items is \$67.25.**

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, plus all accrued interest due at the time of payment, to the Requestor within 20-days of receipt of this Order. Reimbursement for the medical necessity issues is \$67.25.

Findings and Decision by:

7-19-05

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.

July 15, 2005

TEXAS WORKERS COMP. COMMISSION
AUSTIN, TX 78744-1609

CLAIMANT: ____

EMPLOYEE: ____

POLICY: M5-05-2498-01

CLIENT TRACKING NUMBER: M5-05-2498-01

Medical Review Institute of America (MRIoA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Workers Compensation Commission has assigned the above-mentioned case to MRIoA for independent review in accordance with TWCC Rule 133, which provides for medical dispute resolution by an IRO.

MRIoA has performed an independent review of the case in question to determine if the adverse determination was appropriate. In performing this review all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the TWCC approved doctor list (ADL). The reviewer has signed a statement indicating they have no known conflicts of interest existing between themselves and the treating doctors/providers for the patient in question or any of the doctors/providers who reviewed the case prior to the referral to MRIoA for independent review.

Records Received:

FROM THE STATE:

Notification of IRO assignment dated 6/24/05 1 page
Texas Workers Compensation Commission form dated 6/24/05 1 page
Medical Dispute Resolution Request/Response form 2 pages
Provider form 1 page
Table of disputed services 19 pages
Explanation of review dated 6/7/04 – 6/11/04 1 page
Explanation of review dated 6/14/04 – 6/18/04 1 page
Explanation of review dated 6/22/04 – 6/25/04 1 page
Explanation of review dated 6/28/04 – 7/2/04 1 page
Explanation of review dated 7/6/04 – 7/9/04 1 page
Explanation of review dated 7/12/04 – 7/15/04 1 page
Explanation of review dated 7/20/04 – 7/23/04 1 page
Explanation of review dated 8/4/04 – 8/6/04 1 page
Explanation of review dated 8/9/04 – 8/11/04 1 page
Explanation of review dated 8/16/04 – 8/19/04 1 page
Explanation of review dated 8/24/04 – 8/27/04 1 page
Explanation of review dated 9/1/04 – 9/3/04 1 page
Explanation of review dated 10/14/04 – 11/24/04 2 pages
Explanation of review dated 10/20/04 – 10/27/04 1 page
Explanation of review dated 10/29/04 – 11/3/04 1 page
Explanation of review dated 11/5/04 – 11/9/04 1 page
Explanation of review dated 11/11/04 – 11/16/04 1 page
Explanation of review dated 11/29/04 1 page
Explanation of review dated 11/29/04 – 12/1/04 1 page
Explanation of review dated 12/13/04 – 12/15/04 1 page
Explanation of review dated 12/20/04 – 12/22/04 1 page

FROM THE REQUESTOR:

Bose Consulting, LLC list of exhibits 1 page
Exhibit #1 cover sheet 1 page
Position statement 5 pages
Exhibit #2 cover sheet 1 page
MRI of left knee report dated 7/10/03 1 page
MRI of thoracic spine report dated 5/28/02 1 page
MRI of left shoulder report dated 5/28/03 1 page
MRI of left ankle report dated 5/28/02 1 page
Thoracic spine report dated 4/22/03 1 page
Left knee report dated 4/22/03 1 page
Left ankle/lower leg report dated 4/22/03 1 page
Left shoulder report dated 4/22/03 1 page
Exhibit #3 cover sheet 1 page
Progress report dated 7/24/03 2 pages
Progress report dated 6/19/03 2 pages
Progress report dated 5/22/03 2 pages
Consultation report dated 4/24/03 1 page
Consultation report dated 4/24/03 3 pages
Exhibit #4 cover sheet 1 page
History and physical notes dated 12/8/04 1 page
History and physical notes dated 9/14/04 1 page
History and physical notes dated 12/8/04 1 page
History and physical notes dated 12/11/03 1 page
History and physical notes dated 10/9/03 1 page
Operative report dated 9/8/03 2 pages
Operative report dated 10/5/04 1 page
History and physical notes dated 6/18/03 2 pages
History and physical notes dated 9/10/03 1 page
History and physical notes dated 8/13/03 1 page
Exhibit #5 cover sheet 1 page
Letter from Dr. Steele, MD dated 7/12/04 2 pages
Supplemental information on member cover sheet 1 page
Review of medical history and physical exam notes dated 7/12/04 4 pages
Exhibit #6 cover sheet 1 page
Letter from Dr. Schwartz, DC dated 6/3/03 1 page
Follow up note dated 5/3/05 1 page
Exhibit #7 cover sheet 1 page
Horizon health chart notes dated 4/19/03 – 12/22/04 37 pages

FROM THE RESPONDENT:

Chart notes dated 5/6/04 1 page
Chart notes dated 2/5/04 1 page
Chart notes dated 12/11/03 1 page
Chart notes dated 10/9/03 1 page
Chart notes dated 9/10/03 1 page
Chart notes dated 8/13/03 1 page
Chart notes dated 6/18/03 2 pages
Chart notes dated 12/8/04 1 page
Postoperative visit during global period notes dated 10/11/04 1 page
Chart notes dated 9/14/04 1 page
Patient questionnaire dated 8/13/03 1 page
Patient questionnaire dated 12/11/03 1 page
Patient questionnaire dated 10/9/03 1 page
Patient questionnaire dated 9/10/03 1 page
Patient questionnaire dated 12/8/04 1 page
Patient questionnaire dated 10/11/04 1 page
Patient questionnaire dated 5/6/04 1 page
MRI of left shoulder report dated 5/28/02 1 page
Progress report dated 8/4/03 1 page
Progress report dated 8/18/03 1 page
MRI of left knee report dated 7/10/03 1 page
MRI of thoracic spine dated 5/28/02 1 page
MRI of left ankle report dated 5/28/02 1 page

Summary of Treatment/Case History:

The patient is a 43-year-old female who, on ____, slipped on some wet stairs and fell, landing onto her left side and injuring her left shoulder and left ankle. On 5/28/03, an MRI of the left shoulder revealed a partial thickness bursal surface tear of the distal rotator cuff, and an MRI of the left ankle performed on the same day revealed a tear within the anterior talofibular ligament. Despite a conservative trial, the patient eventually underwent left shoulder arthroscopic repair on 9/8/03, followed by post-surgical physical therapy and rehabilitation. On 10/5/04, the patient underwent manipulation under anesthesia for her left shoulder.

Questions for Review:

1. Items in dispute: Were the therapeutic exercises #97110; office visits #99212, #99213; neuromuscular re-education #97112; & manual therapy technique #97140 for 4/12/04 to 12/22/04 medically necessary?

Explanation of Findings:

This reviewer mostly agrees with the carrier in this case, as follows:

The established patient office visit, level III (#99213) performed on date of service 6/7/03 is warranted. All remaining services and procedures are upheld.

In terms of the established patient office visits, levels II (#99212), nothing in either the diagnosis or medical records in this case supported the medical necessity of performing this level of Evaluation and Management (E/M) service routinely on each and every encounter, per CPT, and particularly not during an already-established treatment plan.

Second, insofar as the neuromuscular reeducation service (#97112) was concerned, 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, "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." Although the referral orthopedist recommended "proprioceptive exercises" be provided to the claimant's ankle during his 12/11/03 visit, there was nothing in any of her medical records that documented the presence of proprioceptive disturbances or abnormalities that would support this recommendation. Therefore, the performance of this service was not medically unnecessary.

With regard to the joint mobilization service (#97140), the *Guidelines for Chiropractic Quality Assurance and Practice Parameters* 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 4/12/04, joint mobilization had already been performed on this patient for over a year in duration. If this procedure had been effective, the patient would likely not have needed surgical intervention in the form of either arthroscopic repair or manipulation under anesthesia. Therefore, the continued performance of this procedure "without significant documented improvement" was not medically necessary.

And finally, with regard to the therapeutic exercises (#97110), physical medicine treatment requires ongoing assessment of a patient's response to prior treatment and modification of treatment activities to effect additional gains in function. Continuation of an unchanging treatment plan, performance of activities that could be performed as a home exercise program, and/or modalities that provide the same effects as those that can be self applied, are not indicated.

In fact, services that do not require "hands-on care" or supervision of a health care provider are not considered medically necessary services even if they were performed by a health care provider.

Therapeutic exercises 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. On the most basic level, the provider in this case failed to establish why it was still necessary to provide the therapeutic exercises on a one-on-one basis by 4/12/04 – a full year after she had been performing them – particularly when current medical literature states, "...there is no strong evidence for the effectiveness of supervised training as compared to home exercises." Put another way, after more than a year of monitored instruction, the claimant should certainly have been able to safely perform the exercises on her own. Besides, any gains obtained in this time period would have likely been achieved through performance of a home program anyway. Even if the extensive one-on-one therapeutic exercises had been medically necessary initially, and/or at certain times throughout care (like immediately post-surgically), they would not have been needed for the duration of time in this case.

Conclusion/Partial Decision to Certify:

1. Items in dispute: Were the therapeutic exercises #97110; office visits #99212, #99213; neuromuscular re-education #97112; & manual therapy technique #97140 for 4/12/04 to 12/22/04 medically necessary?

The established patient office visit, level III (#99213) performed on date of service 6/7/03 is warranted. All remaining services and procedures are upheld. See above for rationale.

References Used in Support of Decision:

CPT 2004: Physician's Current Procedural Terminology, Fourth Edition, Revised. (American Medical Association, Chicago, IL 1999),

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

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

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.

This review was provided by a chiropractor who is licensed in Texas, certified by the National Board of Chiropractic Examiners, is a member of the American Chiropractic Association and has several years of licensing board experience. This reviewer has given numerous presentations with their field of specialty. This reviewer has been in continuous active practice for over twenty years.

MRIOA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the treating provider, payor and/or URA, patient and the TWCC.

It is the policy of Medical Review Institute of America to keep the names of its reviewing physicians confidential. Accordingly, the identity of the reviewing physician will only be released as required by state or federal regulations. If release of the review to a third party, including an insured and/or provider, is necessary, all applicable state and federal regulations must be followed.

Medical Review Institute of America retains qualified independent physician reviewers and clinical advisors who perform peer case reviews as requested by MRIOA clients. These physician reviewers and clinical advisors are independent contractors who are credentialed in accordance with their particular specialties, the standards of the American Accreditation Health Care Commission (URAC), and/or other state and federal regulatory requirements.

The written opinions provided by MRIOA represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to MRIOA for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Medical Review Institute of America assumes no liability for the opinions of its contracted physicians and/or clinician advisors. The health plan, organization or other party authorizing this case review agrees to hold MRIOA harmless for any and all claims, which may arise as a result of this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

1167545.1

cb