



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: Pain and Recovery Clinic % Bose Consulting, L. L. C. P. O. Box 550496 Houston, Texas 77255	MDR Tracking No.: M5-05-2753-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Liberty Mutual Insurance Company, Box 28	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included TWCC 60 form, Explanations of Benefits, medical documentation and CMS 1500's. Position summary stated, "Pursuant to TWCC Rules 133.307 and 133.308, find the requisite documentations to be filed with an IRO for medical review."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included TWCC 60 form and Explanations of Benefits. No position summary was received.

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)
1-4-05 – 2-25-05	CPT codes 97110, 97032, 99212, 99214, E1399, 97035, 97112	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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.

In a letter dated 9-27-05 the requestor withdrew CPT code 99080-73 for 1-6-05 and 2-22-05 and dates of service 1-25-05 and 1-28-05. These services will not be a part of this dispute.

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

Findings and Decision by:

9-28-05

Authorized Signature

Typed Name

Date of Findings and Decision

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.



Barton Oaks Plaza Two, Suite 200
901 Mopac Expressway South - Austin, TX 78746-5799
Phone: 512-329-6619 - Fax: 512-327-7159 - www.tmf.org

NOTICE OF INDEPENDENT REVIEW DECISION

September 8, 2005

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker: _____
MDR Tracking #: M5-05-2753-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. TMF's health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 46 year old male injured his neck, head, low back, and left knee on _____. He has been treated with therapy, medications, and surgery.

Requested Service(s)

Therapeutic exercises – 97110; electrical stimulation manual – 97032; office visits – 99212 & 99214; durable medical equipment – E1399; ultrasound – 97035; and neuromuscular re-education – 97112 for dates of service of 01/04/2005 through 02/25/2005.

Decision

It is determined that the therapeutic exercises – 97110; electrical stimulation manual – 97032; office visits – 99212 & 99214; durable medical equipment – E1399; ultrasound – 97035; and neuromuscular re-education – 97112 for dates of service of 01/04/2005 through 02/25/2005 were not medically necessary to treat this patient's condition.

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, 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 on going 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, there is no documentation of objective or functional improvement in this patient's condition and no evidence of a change of treatment plan to justify additional treatment in the absence of positive response to prior treatment.

Specifically, in regard to neuromuscular re-education (97112), there is 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 re-education 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/hyper tonicity). 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. In regard to the continuing passive treatment, it is the position of the Texas Chiropractic Association that it is beneficial to proceed to the rehabilitation phase (if warranted) as rapidly as possible, and to minimize dependency upon passive forms of treatment/care since studies have shown a clear relationship between prolonged restricted activity and the risk of failure in returning to pre-injury status. The TCA Guidelines also state that repeated use of acute care measures alone generally fosters chronicity, physician dependence and over-utilization and the repeated use of passive treatment/care tends to promote physician dependence and chronicity. The ACOEM Guidelines state that passive modalities such as massage, diathermy, TENS units, have no proven efficacy in treating acute low back symptoms and that there is no high-grade scientific evidence to support the effectiveness of passive modalities such as traction, heat/cold application, massage, diathermy, ultrasound, or TENS units for cervical spine conditions. The NASS Guidelines state that passive interventions are indicated during the first 8 weeks only "if clinically indicated and not previously unsuccessful." Based on CPT, there is no support for the medical necessity for an office on most every date of service during an established – and unchanging – treatment plan.

The records failed to substantiate that the disputed services fulfilled statutory requirements for medical necessity since the patient obtained no relief, promotion of recovery was not accomplished (knee ROM was the same on 01/06/2005 and 02/22/2005; plus a subsequent knee surgery was necessary) and there was no enhancement of the employee's ability to return to employment.

Sincerely,

A handwritten signature in black ink that reads "Gordon B. Strom, Jr." The signature is written in a cursive, somewhat stylized font.

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:dm

Attachment

Information Used by TMF in Decision

Patient Name: ____

TWCC ID #: M5-05-2753-01

Medical record documentation provided:

- Respondant's Position
- Peer Review
- Respondant's Progress Notes
- Requestor's Position
- Diagnostic Tests
- Functional capacity evaluation
- Operative Report
- Maximum Medical Improvement
- Requestor's Progress Notes