



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: San Antonio Spine and Rehab 1313 S.E. Military # 107 San Antonio, Texas 78214	MDR Tracking No.: M5-05-2782-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Box 03	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Treatment is reasonable and necessary. Documentation provided includes TWCC-60, CMS 1500s, explanation of benefits and medical notes.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The claimant has a full thickness tear of the rotator cuff. The provider has far exceeded utilization review standards for PT. In addition, the claimant needs surgery. This opinion is supported by a RME. Documentation provided includes response to TWCC-60, CMS 1500s and explanation of benefits.

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)
12-22-04 to 01-17-05	97140-59, 97110-GP, 99212-59, 99212-GP, 99212, 99213-25, 97035 and 97124	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00

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. No reimbursement is due for the services denied for medical necessity.

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 08-11-05, 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 G0283-AT dates of service 12-27-04, 12-28-04 and 12-29-04, code 97113-AT-GP date of service 01-03-05, code 97113-59-AT dates of service 01-05-05, 01-14-05 and 01-17-05, code 97032-AT date of service 01-03-05, code 97035-AT dates of service 01-05-05, 01-14-05 and 01-17-05 and code 97140-59-AT dates of service 01-05-0, 01-14-05 and 01-17-05 were billed with an invalid modifier (AT) per Rule 134.202(b). These services in dispute will not be a part of the review.

CPT code 99212-59 date of service 01-14-05 denied with denial code "150" (payment adjusted because the payer deems the information submitted does not support this level of service). The requestor per Rule 133.307(g)(3)(A-F) submitted documentation to support delivery of service. Reimbursement is recommended in the amount of **\$44.16 (amount in dispute per table submitted by requestor)**.

CPT code 97124-59 date of service 01-14-05 denied with denial code "150" (payment adjusted because the payer deems the information submitted does not support this level of service). The requestor per Rule 133.307(g)(3)(A-F) submitted documentation to support delivery of service. Reimbursement is recommended in the amount of **\$26.28 (amount in dispute per table submitted by requestor)**.

CPT code 99080-73 date of service 01-18-05 denied with denial code "150" (payment adjusted because the payer deems the information submitted does not support this level of service). The requestor per Rule 133.307(g)(3)(A-F) submitted documentation to support delivery of service. Reimbursement is recommended in the amount of **\$15.00** per Rule 133.106(f)(1).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, Rule 133.307(g)(3)(A-F), Rule 133.106(f)(1) and Rule 134.202(b).

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 a refund of the paid IRO fee. The Division has determined that the requestor is entitled to reimbursement in the amount of **\$85.44**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30 days of receipt of this Order.

Findings and Decision and Order by:

Authorized Signature

Typed Name

09-16-05

Date of Order

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.

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

REVISED 9/9/05

TWCC Case Number:	
MDR Tracking Number:	M5-05-2782-01
Name of Patient:	
Name of URA/Payer:	San Antonio Spine & Rehab
Name of Provider: (ER, Hospital, or Other Facility)	San Antonio Spine & Rehab
Name of Physician: (Treating or Requesting)	Joseph J. Flood, DC

August 31, 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. Notification of IRO Assignment, Table of Disputed Services and Carrier EOBs
2. Employer's First Report of Injury or Illness, dated
3. Initial treatment notes (Concentra), multiple dates
4. Initial evaluation and narrative from first doctor of chiropractic, dated 8/9/04, and follow-up daily notes and "Daily Treatment Logs," multiple dates
5. Initial orthopedic consultation narrative, dated 8/11/04, and follow-up notes, multiple dates
6. "P.T. Exercise Flow Sheets," multiple dates
7. Report of functional capacity evaluation, dated 9/21/04
8. Independent medical examination and report, dated 11/18/04
9. Treating doctor's initial narrative, dated 12/20/04

10. Treating doctor's subsequent evaluation reports, dated 1/18/05
11. Physical performance evaluation, dated 3/4/05, 2/3/05
12. Left shoulder MRI report, dated 7/27/04
13. EMG/NCV report, dated 2/10/05
14. Orthopedic consultation report, dated 1/27/05
15. Carrier's position statement, dated 8/12/05
16. Various TWCC-73s, multiple dates
17. Copy of Medicare Policy Statement #Y-13B-R5, referable to "physical medicine and rehabilitation for orthopedic and musculoskeletal diseases and/or injuries," printed from Trailblazers website 2/22/05
18. Copy of Millman Care Guidelines® referable to "Acromioplasty for Impingement Syndrome" and "Rotator Cuff Repair with or without Acromioplasty by Arthroscopy," printed from website 2/22/05

Patient is a 58-year-old janitor for the local _____ who, on ____, was buffing and stripping floors in the cafeteria when the buffing machine suddenly jumped and struck him, knocking him to the floor. He reportedly landed onto his left shoulder, and in the process of falling/landing, some of the stripping chemical burned his face. He was initially treated at the emergency room for his facial burns, but later, his employer sent him to Concentra for evaluation and management of his left shoulder. An MRI was performed on 7/27/04 and it revealed a full thickness tear of the rotator cuff, fluid in both the subacromial and subdeltoid bursas, and moderate degenerative joint disease of the left glenohumeral joint. Physical therapy and rehabilitation was initiated, as well as cortisone injections, but when the patient response was less than expected, the patient was referred to an orthopedic specialist in early August.

However, the patient instead presented himself to a doctor of chiropractic who performed additional extensive physical therapy and rehabilitation, and referred him to an orthopedic surgeon who opined, "I do not believe that surgery will benefit the patient," and recommended more physical therapy. On 11/18/04, he was seen by an IME who felt that he was at MMI with respect to conservative care, and that he otherwise required surgical repair.

But on 12/14/04, the patient secured an approval for a change of treating doctor and presented himself on 12/20/04 to yet another doctor of chiropractic who performed an examination, and then commenced more physical therapy and rehabilitation.

REQUESTED SERVICE(S)

Manual therapy techniques (97140-59), therapeutic exercises (97110-GP), established patient office visits, levels II, III and IV (99212-59, 99212-GP, 99212, 99213-25, and 99214-25, respectively), ultrasound therapy (97035), and massage therapy (97124) for dates of service 12/22/04 through 1/18/05.

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) Evidence of objective functional improvement is essential to establish reasonableness and medical necessity of treatment. Put another way, **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 was 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. By the time this patient changed treating doctors of chiropractic and initiated care, physical medicine

procedures had long been tried and failed. To continue at that point in time with more of the same treatments and procedures in the face of failed outcomes was simply not supported as medically necessary.

Specifically, the *Guidelines for Chiropractic Quality Assurance and Practice Parameters*¹ 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." Certainly by 12/22/04 – the dates in dispute here – these treatments had been attempted for much longer than a 4-week trial period, and had been proven unsuccessful..

¹ Haldeman, S; Chapman-Smith, D; Petersen, D *Guidelines for Chiropractic Quality Assurance and Practice Parameters*, Aspen Publishers, Inc.