

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 Pain & Recovery Clinic-North 6660 Airline Drive Houston, TX 77076	MDR Tracking No.: M5-05-2848-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Texas Mutual Insurance Company, Box 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
8-3-04	8-31-04	CPT codes 99212, 2 units of 97140 per date	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
9-2-04	10-20-04	CPT codes 99212, 2 units of 97140 per date	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
8-3-04	10-20-04	CPT codes 97032, 97035, 97110, 97112	<input type="checkbox"/> Yes <input checked="" 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 services is \$793.83.

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.

On 7-25-05 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 97140 (2 units) on 10-20-04 was denied by the carrier as "936 – this code is invalid, not covered, or has been deleted from the Texas Fee Schedule." The 2002 MFG describes this service as, "Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes." Recommend reimbursement of \$67.80.

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, totaling \$861.63, plus all accrued interest due at the time of payment, to the Requestor within 20-days of receipt of this Order.

Findings and Decision by:

	Donna Auby	8-18-05
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

If you are unhappy with all or part of this decision, you have the right to appeal the decision. Those who wish to appeal decisions that were issued during the month of August 2005, should be aware of changes to the appeals process which take effect September 1, 2005.

House Bill 7, recently enacted by the 79th Texas Legislature, provides that an appeal of a medical dispute resolution order that is not pending for a hearing at the State Office of Administrative Hearings (SOAH) on or before August 31, 2005 is not entitled to a SOAH hearing. This means that the usual 20-day window to appeal to SOAH, found in Commission Rule 148.3, will be shortened for some parties during this transition phase. If you wish to seek an appeal of this medical dispute resolution order to SOAH, you are encouraged to have your request for a hearing to the Commission as early as possible to allow sufficient time for the Commission to submit your request to SOAH for docketing. A request for a SOAH 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.

Beginning September 1, 2005, appeals of medical dispute resolution 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.

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

August 15, 2005

TEXAS WORKERS COMP. COMMISSION
AUSTIN, TX 78744-1609

CLAIMANT: ____

EMPLOYEE: ____

POLICY: M5-05-2848-01

CLIENT TRACKING NUMBER: M5-05-2848-01/5278

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:

Records received from the State:

1. Notification of IRO Assignment, 7/25/05
2. Notice of receipt of request for Medical Dispute Resolution, 7/22/05
3. Medical Dispute Resolution Request/Response form, 6/27/05
4. List of Providers
5. Table of Disputed Services
6. Carrier EOBs

Records Received from the Requestor:

1. Letter from Constance Whest, Pain & Recovery Clinic, 8/11/05
2. Table of Disputed Services
3. Requestor's position statement, not dated
4. Initial doctor's intake forms, dated 2/20/04
5. Texas Workers Compensation Work Status Reports, 2/20/04, 4/2/04, 4/12/04, 4/16/04, 4/30/04, 5/7/04, 5/21/04, 6/18/04, 8/3/04, 8/18/04, 9/15/04, 10/20/04, 11/18/04, 12/3/04, 12/9/04, 12/17/04
6. Initial treating doctor's "Physical therapy daily notes" and examination records from 2/23/04 through 6/2/04
7. MRI report, cervical spine and right shoulder, dated 3/19/04
8. Second interpretation of cervical and shoulder MRIs, dated 3/19/04
9. Patient questionnaire, 6/15/04
10. Letter from Michele Gatlin, Texas Mutual, 5/18/04
11. Letter from office of Donald Nowlin, MD to inform patient of independent Medical Examination date, 5/18/05
12. Independent medical examination and report, Donald Nowlin, MD, dated 6/21/04
13. Work/Comp History form, undated, unsigned
14. Properly signed and approved TWCC-53, dated 8/5/04
15. New treating doctor's initial evaluation and report, dated 8/3/04
16. New treating doctor's "daily progress notes," from 8/3/04 through 10/20/04
17. Subsequent medical report, Dean McMillan, MD, 8/18/04, 9/15/04, 10/20/04, 11/18/04, 12/17/04
18. Pain Institute of Texas, pain management consultation narratives, dated 8/19/04, 9/9/04, 9/30/04, 11/8/04
19. Prescriptions, 8/18/04, 9/18/04, 10/20/04, 11/18/04, 12/3/04
20. Carrier denial for cervical ESI, dated 8/24/04
21. EMG/NCV report, dated 9/23/04
22. Consultation by doctor of chiropractic and narrative report, dated 9/29/04
23. Shanti Pain and Wellness, assessment/evaluation, dated 10/22/04
24. Letter from Dean McMillan, MD, 10/22/04

25. Designated doctor examination, report and TWCC-69, dated 10/25/04
26. Report of Medical Evaluation and Impairment Rating, John Andrew, MD, 10/25/04
27. Orthopedic surgeon's evaluation and report, dated 10/26/04
28. Operative report (cervical ESI and nerve root injection), dated 11/17/04
29. Progress notes, Dean McMillan, MD, 12/3/04, 12/9/04
30. Treating doctor's impairment rating and report, and TWCC-69, dated 12/13/04
31. Letter from Dean McMillan, Re: Request for Letter of Clarification, 1/21/05
32. Letters from Dean McMillan, Re: Designated Doctor Dispute, 4/6/05, 5/23/05

Summary of Treatment/Case History:

Patient is a 38-year-old machinist who, on ____, lifted a heavy rubber pipe and felt a popping pain in the back of his neck with radiation of pain and tingling into his right shoulder and down his right arm. He presented himself to a medical doctor who initiated treatment that consisted of medications and physical therapy. An MRI of the cervical spine was performed approximately one month later that revealed a diffuse bulge at C3-4, and an MRI of the right shoulder revealed rotator cuff tendonitis, a grade I impingement, and possibly a small tear.

In August of 2004, the patient secured a change of treating doctors and began treatment with a multi-disciplinary practice that subsequently performed similar therapy procedures, but added chiropractic treatments. Then, an EMG/NCV performed in September revealed a compromised C7-8 nerve root affecting the right upper extremity, so an ESI was attempted in November. The patient had already been seen by a designated doctor on 10/25/04 who determined that he was already at MMI with a 2% whole-person impairment. The treating doctors disagreed with that assessment, and on 12/13/04, performed their own impairment rating examination and determined the patient was at MMI on that later date with an 8% whole-person impairment.

Questions for Review:

1. Were the manual therapy techniques (#97140), electrical stimulation, attended (#97032), therapeutic ultrasound (#97035), established patient office visit, level II (#99212), therapeutic exercises (#97110), and neuromuscular reeducation (#97112) from 8/3/04 through 10/20/04 medically necessary to treat this patient's injury?

Explanation of Findings:

Upon careful review of the medical records from the initial treating doctor, it is demonstrated that therapeutic exercises (#97110) and electrical stimulation (#97032) – as well as many other treatments and procedures including therapeutic ultrasound (#97035) and neuromuscular reeducation (#97112) – had already been attempted and failed. Therefore, the medical necessity of performing “more of the same” in the face of limited response was not supported. And in the case of the therapeutic exercises, after so many months of participation in a supervised exercise program, it would have been safe to transition the patient into a home exercise program. If not, at the very least the provider should have documented the circumstances prohibiting this transition into a home program, particularly when current medical literature states, “. . .there is no strong evidence for the effectiveness of supervised training as compared to home exercises.” (Ref. 1) Any gains recorded during this time period would likely have been achieved through performance of a home program.

In the case of the manual therapy techniques (#97140) provided by the doctor of chiropractic, the medical records demonstrated that this was a new service and one that had not been attempted. Therefore, it was both reasonable and necessary to perform a clinical trial utilizing this procedure. However, the *Guidelines for Chiropractic Quality Assurance and Practice Parameters* (Ref. 2) 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.” According to the “daily progress notes,” date of service 8/3/04 – under “objective findings/treatment intervention” – stated, “There is tenderness and restricted range of motion of the cervical and right shoulder. +Jackson's/ +SH depression/ +MFC with radiating pain into right cervicothoracic junction and right upper extremity/ +impingement sign. Weakness of the right upper extremity. MRI revealed disc bulge at C3-C4, impingement syndrome of the right shoulder.” On dates of service 8/27/04 and 9/2/04, the *exact same observations were recorded*. In addition, on 8/27/04, under “subjective complaints,” the box for “same” was checked in response to the question/assessment, “same, better or worse?” Therefore, since 4 weeks of manual therapy at that point failed to render “significant documented improvement,” continued manual therapy techniques after date of service 8/31/04 was not supported as medically necessary.

Conclusion:

1. Were the manual therapy techniques (#97140), electrical stimulation, attended (#97032), therapeutic ultrasound (#97035), established patient office visit, level II (#99212), therapeutic exercises (#97110), and neuromuscular reeducation (#97112) from 8/3/04 through 10/20/04 medically necessary to treat this patient's injury?

Decision to Certify:

All established patient office visits, level II (#99212) were medically necessary, as are two units of manual therapy techniques (#97140) from 8/3/04 up to and including date of service 8/31/04.

Decision to Not Certify:

Electrical stimulation, attended (#97032), therapeutic ultrasound (#97035), therapeutic exercises (#97110), and neuromuscular reeducation (#97112) from 8/3/04 through 10/20/04 were not medically necessary to treat this patient's injury.

Established patient office visits, level II (#99212) and manual therapy techniques (#97140) were not medically necessary after 8/31/04.

References Used in Support of Decision:

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

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.

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