



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:	MDR Tracking No.: M5-05-2883-01
Southeast Health Services Inc PO Box 453062 Garland TX 75045	Claim No.:
	Injured Worker's Name:
Respondent's Name and Address:	Date of Injury:
Liberty Mutual Box 28	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DWC-60 package, EOBs, CMS-1500s. Position summary as stated on the table of disputed services: Please note that at the time of the peer review, the following information was not made available to the peer review doctor. The patient had an MRI that revealed thinning of the discs in the cervical spine, a protrusion in the lumbar spine and abnormalities in the shoulder MRI.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DWC-60 response and EOBs.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
7-2-04 to 7-23-04	98941 (\$ 46.49 X 3 days = \$139.47) 97032 (\$ 20.20 X 2 days = \$ 40.40) 97016 (\$ 18.40 X 2 days = \$ 36.80) 97035 (\$ 15.84 X 2 days = \$ 31.68) 97012 (\$ 19.21) 97140-59 (\$ 34.13 X 4 days = \$136.52) 97110 (\$ 36.00) 99211 (\$ 27.86)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$467.94
	98943 (value x 2 days)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	See rule 134.202(c)(6) for reimbursement value
7-28-04 to 2-24-05	98941, 97140-59, 97110, 99211, 98943, 97032, 97016, 97012, 99213-25, 97799, 97024, 97530, 99214-25, 97535	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
7-2-04 to 2-24-05	97113	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
	TOTAL		\$467.94 plus the value of 98943

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 majority of the disputed medical necessity issues.

Rule 134.202(c)(6) states, for products and services for which CMS or DWC does not establish relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published DWC medical dispute decisions, and values assigned for services involving similar work and resource commitments. Therefore, the carrier shall assign the reimbursement value for code 98943.

Based on review of the disputed issues within the request, Medical Review 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 Medical Dispute Resolution.

Code 99080-73 billed for date of service 9-12-04 was denied as unnecessary medical; however, per Rule 129.5, this is a required report and is not subject to an IRO review. Medical Review has jurisdiction in this matter. Since the office visit on this same date was deemed not medically necessary, the report cannot be recommended for reimbursement.

The carrier submitted proof of payment (check # 11037577 & 1103578 issued on 7-22-05) for code 99080-73 billed on dates of service 12-2-04 and 1-4-05 and verified by requestor. Therefore, no dispute exists.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.202

PART VII: DIVISION DECISION AND ORDER

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 entitled to additional reimbursement in the amount of \$467.94 plus value of code 98943 x 2 days. In addition, the Division finds that the requestor is not the prevailing party and is not entitled to a refund of the paid IRO fee. 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.

Ordered by:

_____, Medical Dispute Officer

11-21-05

Authorized Signature

Typed Name

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.

IRO America Inc.

An Independent Review Organization
7626 Parkview Circle
Austin, TX 78731
Phone: 512-346-5040
Fax: 512-692-2924

Amended November 15, 2005
October 28, 2005

TDI-DWC Medical Dispute Resolution
Fax: (512) 804-4868

Patient: _____
TDI-DWC #: _____
MDR Tracking #: M5-05-2883-01
IRO #: 5251

IRO America Inc. (IRO America) has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI, Division of Workers' Compensation (DWC) has assigned this case to IRO America for independent review in accordance with DWC Rule 133.308 which allows for medical dispute resolution by an IRO.

IRO America has performed an independent review of the proposed care 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.

The independent review was performed by a matched peer with the treating doctor; the Reviewer is a credentialed Panel Member of IRO America's Medical Knowledge Panel who is a licensed Provider, board certified and specialized in Chiropractic Care. The reviewer is on the DWC Approved Doctor List (ADL).

The IRO America Panel Member/Reviewer is a health care professional who has signed a certification statement stating that no known conflicts of interest exist between the Reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carriers health care providers who reviewed the case for decision before referral to IRO America for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

RECORDS REVIEWED

Notification of IRO Assignment, records from the Requestor, Respondent, and Treating Doctor(s), including:

1. Medical Dispute Resolution Request/Response.
2. Explanation of Payment reports, 7-2-04 through 2-24-05.
3. Cervical MRI report, 6-23-04.
4. Lumbar MRI report, 6-23-04.
5. FCE, 6-13-04.
6. Right shoulder MRI, 8-2-04.
7. Chiropractic Modality Review, 8-26-04.
8. Peer Review by Gary Martin, D.C., 6-3-05.
9. Peer Review by Karl Irwin, M.D., 6-23-05.
10. Letter of Medical Necessity for Disputed Services report, 6-29-05.
11. Report from Virginia Cullipher, RN, 10-18-05.

CLINICAL HISTORY

According to the records reviewed, the patient was a 22 year old female working for _____ on _____ when she sustained a work related injury. The patient was initially evaluated by Grady McMahan, D.O. on 5-14-04. Apparently, the patient fell and landed on her right hip and right rib, striking a garbage can. Diagnoses included contusion of the rib cage and hip.

The patient presented to the emergency room on 5-15-04 complaining of increased pain. Hip x-rays and lumbar x-rays were unremarkable. On 5-31-04, the patient was returned to work without restrictions.

The patient was evaluated by Bryan Weddle, D.C. on 5-26-04 and treatment included passive procedures including manipulation, ultrasound, electrical stimulation, and manual therapy. On 7-22-04, aquatic therapy was implemented. The patient was taken off work completely.

On 6-15-04, Dr. Charles Willis prescribed the patient Ultracet and Robaxin.

Cervical MRI was performed on 6-23-04 denoting:

1. Straightening of the cervical curvature.
2. Desiccation at C2-3 and thinning of the discs of the mid to lower cervical and upper thoracic spine indicative of degenerative changes.
3. Normal cord signal intensity.
4. Uncovertebral joint and apophyseal joint hypertrophy on the right side at C3-4 minimally narrowing the inner-to-outer zone of the neural exit foramen.
5. No acute fracture or instability.

Lumbar MRI dated 6-23-04 denoted:

1. Facet arthrosis throughout the lumbar range associated with bilateral effusions at L4-5 and unilateral effusions at L3-4 indicative of post-inflammatory changes.
2. Thinning of the disk at L5-S1 indicative of early degenerative changes.
3. 1 mm disc bulge at L3-L4.
4. 1 mm broad-based protrusion at L4-L5.

FCE dated 7-13-04 indicated the patient was functioning in the "Sedentary" physical demand level.

Right shoulder MRI dated 8-2-04 denoted:

1. Normal glenohumeral alignment without evidence for labral or ligamentous disruption.
2. Evidence of bicipital tenosynovitis, subacromial bursitis and subdeltoid bursitis.
3. Tendonosis/tendonopathy of the distal supraspinatus tendon without evidence of full thickness tears.

Dr. Weddle returned the patient to work without restrictions on 9-9-04; however, placed the patient back on restrictions on 11-11-04. On 11-24-04, the patient received bilateral lumbar facet injections at L4-5 and L5-S1. On 5-18-05, it was determined the patient reached maximum medical improvement and was assigned 12% WPI. A peer review was performed by Gary Martin, DC and Karl Erwin, M.D. on 6-3-05.

Dr. Weddle submitted a Letter of Medical Necessity on 6-29-05 indicating that he felt his treatment was reasonable and necessary.

DISPUTED SERVICE(S)

Under dispute is retrospective medical necessity of chiropractic manipulation (98940, 98941, and 98943), electrical stimulation (97032), vasoneumatic devise (97016), ultrasound (97035), mechanical traction (97012), manual therapy (97140-59), therapeutic exercise (97110), office visits (99211, 9 9214-25, and 99213-25), aquatic therapy (97113), unlisted physical medicine and/or rehabilitation (97799), diathermy (97024), therapeutic activities (97530), and self-care/home management training (97535) from 7-2-04 through 2-24-05.

DETERMINATION/DECISION

The Reviewer partially agree with the determination of the insurance carrier in this case. The chiropractic items in dispute between 7-28-04 and 2-24-05 **do not** appear reasonable or necessary to treat the compensable injury; however, the items in dispute between 7-2-04 and 7-23-04 **do** appear reasonable and necessary with the exception of 97113.

RATIONALE/BASIS FOR THE DECISION

The treatment through 7-23-04 appears reasonable and necessary with the exception of 97113. This treatment falls within guideline parameters (Official Disability Guidelines, NAAS Guidelines, ACOEM Guidelines and Mercy Guidelines).

However, based on The Reviewer's review of the documentation provided, the treatment performed between 7-28-04 and 2-24-05 does not appear reasonable or necessary for numerous reasons.

First, the treatment provided extends far beyond guideline parameters. This patient sustained a lumbosacral sprain/strain, cervical sprain/strain, and shoulder sprain/strain injury as a direct result of the work event. There is no objective documentation to indicate the advanced imaging findings demonstrate an acute injury such as disc herniation and/or rotator cuff tear. In fact, the architectural disturbances denoted on imaging are more consistent with a degenerative process of life. The Official Disability Guidelines indicates the typical lumbar sprain/strain will require 9-18 sessions of chiropractic/physical therapy treatment over a 6-8 week timeframe. The typical 'moderate' cervical sprain/strain injury will require 20 sessions of chiropractic/physical therapy treatment over 6-8 weeks and the typical shoulder sprain/strain injury will require 9 sessions of chiropractic/physical therapy treatment over 8 weeks. Essentially, the patient's sprain/strain injuries should have been successfully rehabilitated and the patient discharged independent with home pain control measures and home exercises within 6-8 weeks (7-23-04).

Second, the aquatic therapy performed was not reasonable or necessary to treat the effects of the injury. Aquatic therapy is considered medically appropriate for individuals who are unable to "safely" participate in a physical therapy program that is totally land-based due to weight-bearing restrictions, severe weakness or neurological conditions. The documentation must support the necessity of this intervention. Clinical examples of the need for skilled aquatic therapy include an individual with severe arthritis who cannot ambulate on land, an individual who recently had a total hip replacement with weight-bearing restrictions or an individual with Guillain Barre' or Multiple Sclerosis who is too weak to exercise on land.

Third, the treatment included an excessive amount of passive care including manipulation, ultrasound, electrical stimulation, mechanical traction, and manual procedures. The Philadelphia Panel of Physical Therapy found insufficient medical evidence to support passive care beyond the initial 6-8 weeks. The use of such passive interventions should be time-limited. In fact, excessive use of passive procedures has been shown to actually foster physician dependency, over-utilization, somatization, and even a disability mindset.

Fourth, The Reviewer does not believe the treatment enhanced the ability of the patient to return to work. The Official Disability Guidelines (ODG) reviewed 6,057 cervical sprain/strains, 20,895 lumbar sprain/strains, and 25,582 shoulder sprain/strains and found the patients typically returned to work within 16-28 days, 14-17 days and 7-16 days respectively. This patient was taken off work completely through 7-19-04 and in fact could not tolerate full duty. The most meaningful outcome measurement tool available is the rate of return to work and the ability to sustain full duty employment. In The Reviewers medical opinion, the documentation does not clearly indicate the treatment effectively returned this patient to work at a greater rate than what would be witnessed in the natural history. In fact, according to the ODG, the natural history would indicate a more expeditious recovery is seen without treatment.

Fifth, the ultimate goal of any treatment is improved functional tolerance. The documentation fails to demonstrate functional improvement with relevant clinical findings such as range of motion, strength/endurance, or orthopedic testing. Additionally, the documentation does not quantify perceived functional abilities with subjective outcome assessment tools such as Oswestry Questionnaires, Neck Disability Index Questionnaires or Croft's Measurement of Shoulder Disability Questionnaires. These have been shown to be valid and reliable means of quantifying functional improvement.

Sixth, there is no documentation of lasting subjective improvement within the documentation supplied. Additionally, the documentation does not include routine SOAP notes, re-evaluations, or exercise logs to support the treatment provided beyond 7-23-04.

Seventh, the DRX/Matrix is essentially the application of an electrical modality as well as axial decompression to relieve inter-distal and facet pressure. This is an extremely expensive form of axial decompression and lacks well-controlled medical evidence to support its use. The research that has been conducted on this has been of an uncertain quality and performed by individuals with a financial interest in the unit making it difficult to recommend it as a proven and cost-effective intervention. One study performed was not a randomized clinical trial and the Sherry et al. study had a very small N (44). Additionally, 28 sessions of this intervention is completely excessive.

In summary, the documentation does not clearly demonstrate the treatment relieved the effects of the injury, objectively promoted recovery, or enhanced the ability of the patient to maintain employment. The ACOEM Guidelines indicate excessive use of in-office care has been shown to actually delay functional recovery. The Reviewer believes the care extending beyond 7-23-04 was in fact excessive and unnecessary.

Screening Criteria

1. Specific:

Official Disability Guidelines, NAAS Guidelines, ACOEM Guidelines and Mercy Guidelines

2. General:

In making his determination, the Reviewer had reviewed medically acceptable screening criteria relevant to the case, which may include but is not limited to any of the following: Evidence Based Medicine Guidelines (Helsinki, Finland); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Texas Chiropractic Association: Texas Guidelines to Quality Assurance (Austin Texas); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Mercy Center Guidelines of Quality Assurance; any and all guidelines issued by DWC or other State of Texas Agencies; standards contained in Medicare Coverage Database; ACOEM Guidelines; peer-reviewed literate and scientific studies that meet nationally recognized standards; standard references compendia; and findings; studies conducted under the auspices of federal government agencies and research institutes; the findings of any national board recognized by the National Institutes of Health; peer reviewed abstracts submitted for presentation at major medical associates meetings; any other recognized authorities and systems of evaluation that are relevant.

CERTIFICATION BY OFFICER

IRO America has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. IRO America has made no determinations regarding benefits available under the injured employee's policy.

As an officer of IRO America Inc., I certify that there is no known conflict between the Reviewer, IRO America and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

IRO America is forwarding by mail or facsimile, a copy of this finding to the DWC.

Sincerely,

IRO America Inc.



Dr. Roger Glenn Brown

President & Chief Resolutions Officer

Your Right To Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). 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. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.