

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 Valley Spine Medical Center 5327 South McColl Rd. Edinburg, Texas 78539	MDR Tracking No.: M5-05-2912-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address American Home Assurance Company, Box 19	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		
12-27-04	1-4-05	CPT codes 97110, 97035, 97124, 97140, E0745	<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 disputed medical necessity issues.

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 8-9-05 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 97124 from 11-10-04 through 12-21-04 (13 dates of service) was denied as "435 – the value of this procedure is included in the value of the comprehensive procedure." Per the 2002 MFG this service is included in the value of CPT code 97140 which was performed on these dates of service. Recommend no reimbursement.

CPT code 97035 on 11-23-04, 11-29-04, 12-01-04, 12-6-04, 12-8-04, 12-9-04, 12-13-04, 12-15-04, 12-17-04, and 12-22-04 was denied as "213 – the charge exceeds the scheduled value or parameters that would appear reasonable." In accordance with 134.202(b): for billing, reporting, and reimbursement of professional medial services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies. Recommend reimbursement of \$148.10 (\$14.81 X 10 DOS).

CPT code 97140 on 11-23-04, 11-29-04, 12-01-04, 12-6-04, 12-8-04, 12-9-04, 12-15-04, 12-17-04, 12-20-04, 12-21-04 and 12-22-04 was denied as "213 – the charge exceeds the scheduled value or parameters that would appear reasonable." In accordance with 134.202(b): for billing, reporting, and reimbursement of professional medial services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies. Recommend reimbursement of \$349.03 (\$31.73 X 11 DOS).

CPT code 97110 from 11-23-04 through was denied as "213 – the charge exceeds the scheduled value or parameters that would appear reasonable." Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Reimbursement not recommended.

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 reimbursement for the services involved in this dispute 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 \$457.13, 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	8-30-05
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 29,2005

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-05-2912-01
TWCC#: _____
Injured Employee: _____
DOI: _____
SS#: _____
IRO Certificate No.: IRO 5055

Dear ____:

IRI has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc. and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is licensed in chiropractic, and is currently on the TWCC Approved Doctor List.

Sincerely,

Gilbert Prud'homme
General Counsel

GP:thh

REVIEWER'S REPORT
M5-05-2912-01

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

From Requestor:

- Letter of medical necessity
- Correspondence
- Office notes 11/08/04 – 01/21/05
- Physical therapy notes 11/10/04 – 02/07/05
- Radiology reports 02/11/03 – 11/17/04

From Respondent:

- Correspondence

From Pain Management Specialist:

- Office notes 02/02/04 – 11/03/04

Clinical History:

Patient is a 40-year-old female greeter for a large, national department store who, on ____, “rushed” to grab a shopping cart for a customer with her left arm and felt an immediate, sharp pain in her left shoulder. She first presented herself to her family doctor the next day, and he referred her to physical therapy. On 11/8/04, she changed to a multi-disciplinary practice and began medical and chiropractic care that included physical therapy and rehabilitation. An MRI of her left shoulder was performed on 11/17/04, and it revealed tendinosis of the subscapularis and supraspinatous muscles without rupture or tear.

Disputed Services:

Office visits (99212/99213), therapeutic exercises (97110), ultrasound (97035), massage therapy (97124), manual therapy technique (97140 and neuromuscular re-education (E0745) during the period of 12/27/04 thru 01/04/05.

Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were not medically necessary in this case.

Rationale:

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; and (D) 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.

But 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. Specifically, the initial evaluations by the treating doctor of chiropractic as well as the attending medical physician were devoid of any **objective, measurable** documentation on which to gauge response to care (for example, specific range of motion values). In addition, although the daily records had an area to indicate “pain levels” on a scale of 1-10, these portions of the forms were never filled out, so it was also impossible to determine if the patient even **subjectively** improved with the care provided. And, since the records clearly documented that the patient remained off work during the time frame in dispute, the care at issue here failed to meet the statutory requirements¹ for medical necessity because relief was not documented, promotion of recovery was not documented, and there was no enhancement of the employee’s ability to return to employment.

Furthermore, the *Guidelines for Chiropractic Quality Assurance and Practice Parameters 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.” [emphasis added] Since the services in question occurred well after what would have been a four-week trial (care commenced on 11/8/04, and the dates of service in dispute began on 12/27/04), and since “significant documented improvement” was not clearly provided in the documentation submitted, the medical necessity of these services was unsupported.

¹ Texas Labor Code 408.021

² Haldeman, S; Chapman-Smith, D; Petersen, D *Guidelines for Chiropractic Quality Assurance and Practice Parameters*, Aspen Publishers, Inc.