



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

<b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address: Southeast Health Services P O BOX 170336 Dallas, Texas 75217	MDR Tracking No.: M5-05-2928-01
	Claim 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: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION PROVIDED: TWCC-60, explanation of benefits, medical documentation and CMS 1500s. POSITION SUMMARY: Please see the attached letter of medical necessity to support the services provided to this patient.

#### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION PROVIDED: Response to TWCC-60 and explanation of benefits. POSITION SUMMARY: This dispute involves the carrier's payment for date of service 7/8/2004 to 10/25/2004. The requestor billed \$4,583.00; Texas Mutual paid \$0.00. The requester believes it is entitled to an additional of \$4,278.67.

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
07-12-04, 07-16-04, 08-05-04, 08-09-04, 08-12-04 and 08-16-04	98940 (2 units @ \$33.61) = \$67.22 98941 (4 units @ \$45.00) = \$180.00 98943 (4 units @ \$35.00) = \$140.00 97140-59 (5 units @ \$34.13) = \$170.65 97032 (3 units @ \$20.20) = \$60.60 97016 (3 units @ 18.40) = \$55.20 E0745 @ \$495.00 = \$495.00 97139-TN (1 unit @ \$20.30) = \$20.30 97110 (2 units @ \$36.00) = \$72.00 99214 (1 unit @ \$106.36) = \$106.36	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,367.33
07-08-04, 07-20-04, 07-26-04, 07-27-04, 07-30-04, 07-31-04, 08-02-04, 08-19-04 to 09-03-04, 09-10-04 to 09-27-04, 10-04-04 and 10-11-04	98941, 98943, 97140-59, 97110, 98940, 99214 and 99211	<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 **majority** of 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. This dispute also contained services that were not addressed by the IRO and will be reviewed by Medical Dispute Resolution.

On 08-09-05, 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.

Review of codes 09040, 97140-59 and 97110 date of service 10-01-04 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing evidence of carrier receipt of the providers request for EOBs. No reimbursement is recommended.

CPT code 99214 date of service 09-07-04 denied with denial code -N/TG- (not appropriately documented/documentation does not support the service billed. Carriers may not reimburse the service at another billing codes value per Rule 133.301(B). A revised CPT code or documentation to support the service billed may be submitted. Per Rule 133.307(g)(3)A-F) the requestor submitted documentation supporting the service in dispute. Reimbursement per Rule 134.202(c)(1) is recommended in the amount of **\$106.36 (\$85.09 X 125%)**.

CPT code 98941 dates of service 10-22-04 and 10-25-04, code 97140-59 and 97110 date of service 10-22-04 denied with denial code -K/287- (not applicable HCP/Service is denied because the doctor is not on the Texas approved doctors list (ADL) for this date of service. Dr. Mark McMahon provided services on the dates in dispute. Verification was made that Dr. McMahon was not on the ADL for these dates of service. No reimbursement recommended.

CPT code 97140 (1 unit) date of service 10-25-04 denied with denial code -F- (Fee Guideline MAR reduction). The carrier has made no payment. Reimbursement per Rule 134.202(c)(1) is recommended in the amount of **\$34.13 (\$27.30 X 125%)**.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. 133.308, Rule 133.307(e)(2)(B), Rule 133.307(g)(3)(A-F), Rule 134.202(c)(1), Approved Doctor List

**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 reimbursement in the amount of \$1,507.82. In addition, the Division finds that the requestor was not the prevailing party and is not entitled to a refund of the 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.

Findings and Decision and Order by:

09-27-05

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date of Decision and 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 9/26/05**

TWCC Case Number:	
MDR Tracking Number:	M5-05-2928-01
Name of Patient:	
Name of URA/Payer:	Southeast Health Services
Name of Provider: (ER, Hospital, or Other Facility)	Southeast Health Services
Name of Physician: (Treating or Requesting)	James Syvrud, DC

September 7, 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

Available documentation received and included for review consists of initial and subsequent reports and treatment records from Drs Weddle (DC) and Willis (MD); designated doctor report from Dr. Drummond (DO); MRI reports.

Mr. \_\_\_\_, a 30-year-old male, was involved in a work-related accident, whereby while working as a valet, he was trapped and squeezed between two cars. He was in the process of getting into one vehicle when a second vehicle pinned him between it and his vehicle's car door. He reported low back, hip, mid back and neck pain. He did not seek treatment until a month later on 1/26/04 when he present to Brian Weddle, DC.

MRI of the lumbar spine was obtained on 3/9/04 and revealed disc desiccation at L4-5 and L5/S1 with posterior disc bulging both levels, more diffusely at L4/5 and more prominent at the midline of L5/S1 level. The disc material abuts the traversing S1 nerve roots bilaterally at the L5/S1 interspace without any obvious compression or displacement. Facet hypertrophy present bilaterally without significant central or foraminal stenosis at L4-5 and L5-S1.

MRI of the cervical spine was obtained on 8/4/04 and revealed 1 mm bulges at C5-6 and C6-7 with minimal narrowing of the inner zone of the neural exit foramina bilaterally, desiccation of the discs of the mid to upper cervical spine with thinning at C4 through T3, indicative of degenerative change, and a 1mm bulge of the annulus at C3/4 with associated uncovertebral joint hypertrophy bilaterally, narrowing the neural exit minimally on both sides, left greater than right. MRI of the thoracic spine on 8/4/04 revealed desiccation and thinning of T6/7 and T11/12 discs associated with Schmorl's node formation, 0.5 mm bulge of the annulus of T6/7.

The patient was placed on a treatment regime consisting of spinal manipulation with adjunctive physiotherapeutic modalities, primarily lumbar traction with an axial decompressive traction machine, myofascial release, phase a pneumatic therapy, electrical stimulation hot/cold packs and exercises.

The patient had frequent flare-ups throughout his course of care, he was co-managed to by a pain management specialist, Dr. Willis, who initially evaluated him on 1/29/04 with a diagnosis of status post crush injury, acute dorsal, lumbosacral and neck strains, with sacroiliac joint dysfunction and possible lumbar facet syndrome. He prescribed medication including Darvocet. Lumbar ESI was performed 6/16/04. He later treated the patient with trigger point injections for myofascial pain, Treatments noted were on 8/10/04 to the left trapezius; left occipital nerve block on 10/27/04.

Designated doctor appointments on 8/6/04, complaints were pain and swelling in the left shoulder with a lack of movement in the neck, mostly on the left. Exam revealed full range motion to the shoulder, minimal pain in the left shoulder, full cervical range motion with some pain and stiffness on right lateral flexion. No muscle spasm evident.

According to the supporting documentation, the patient had a flare-up of his symptoms on 7/12/04 which appeared resolved back to 'baseline' by 7/16/04, another flare-up occurred on 8/05/04 which lasted through 8/16/04 (a trigger point injection was also performed in this intervening period).

## REQUESTED SERVICE(S)

Medical necessity of chiropractic manipulation (98940/98941/98943), therapeutic exercises (97110), electrical stimulation (97032), office visits (99211/99214), manual therapy (97140) vasopneumatic devices (97016), DME E0745-NU, unlisted therapeutic procedure (97139). 7/8/04-10/11/04

## DECISION

Approve all disputed services on 7/12/04, 7/16/04, 8/5/04, 8/9/04, 8/12/04, and 8/16/04.

Deny all other services disputed.

## RATIONALE/BASIS FOR DECISION

*The standard of medical necessity in Workers Comp, according to the Texas labor code 408.021 (entitlement to medical benefits) is that an employee who sustained a compensable injury is entitled to all healthcare reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to healthcare that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment.*

Unfortunately, at a point some seven or eight months post injury, in order for a patient to be receiving ongoing care in such an ongoing, undeviating fashion, there needs to be some supporting evidence as to why this particular care falls

outside of the "average" expected care time frame that is usually attributed to sprain/strain injuries. Eighty-five percent of mechanical pain patients are better in six weeks<sup>(3)</sup>, therefore less than 15% of patients should receive care which outlasts natural history. In order to receive care which is reimbursable, history and examination should identify and document risk factors defending further care necessity.

Unfortunately, in this case no progression / response / deviation to the program is indicated by the documentation to support continuing care. The records are somewhat repetitious, contain minimally clinically useful information and do not show significant progress / substantive change in treatment. Unfortunately this provides precious little clinical insight as to the patient's status, his progression or improvement/response to care. The supplied documentation and clinical record as a whole demonstrates a paucity of information in terms of reasonable outcome assessment measures, or of any level of descriptive, quantifiable objective data subsequently per date of encounter. The available records did not demonstrate any degree of objective improvement with care,

Any continuing care is not warranted unless justified by appropriate clinical evidence of deterioration from an established baseline with subsequent necessity determined by measuring standardized and objective standards of improvement demonstrating the requirement for continued, ongoing care.

The documentation does assert that flare-ups occurred on the 7/12/04 and 8/5/04, and it is appropriate for some supportive care for these episodes, as this appears to be a deviation from a baseline.

Continuing (chiropractic) care otherwise appears to be beyond current clinical standards and does not appear to satisfy any of the above three mandates of medical necessity. The patient appears to be suffering minimal subjective complaints with no objective findings identified and with no documented indication that continued care is providing any dramatic change to the clinical picture.

#### **References:**

1/ Hansen DT: Topics in Clinical Chiropractic, 1994, volume one, No. 4, December 1994, pp. 1-8 with the article "Back to Basics: Determining how much care to give and reporting patient progress".

2/ The U.S. Department of Health and Human Services Agency For Health-Care Policy and Research (AHCPR), publication No. 95-0643 entitled Acute Low Back Problems in Adults: Assessment and Treatment. This publication provides valuable information regarding appropriate and necessary initial assessment information, medical history, physical examination, pain behavior, initial care plan, special studies and diagnostic tests, and additional management considerations.

3/ Haldeman S., Chapman-Smith D, Peterson DM., eds. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen: Giathersburg, MD, 1993;

(a) Chapter 8, pp. 115-129.

(b) Frequency and duration of care.

4/ Shekelle PG, Adams AH, Chassin MR, et al: The Appropriateness of Spinal Manipulation for Low Back Pain, Indications and Ratings of a Multidisciplinary Expert Panel, Santa Monica, California: RAND; 1991

5/ Souza T: Differential Diagnosis for a Chiropractor: Protocols and Algorithms, 1997; chapter 1, pp. 3-25.

6/. Liebenson C. Commentary: Rehabilitation and chiropractic practice.

JMPT 1996; 19(2):134140

7/ Québec Task Force on Spinal Disorders. Scientific approach to the assessment and management of activity-related spinal disorders: a monograph for clinicians. Spine. 1987;12:51-59.