



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: David M. Griffith, D. C. 30525 Quinn Road #A Tomball, TX 77375	MDR Tracking No.: M5-05-2957-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: TX Hospital Insurance Exchange, Box 06	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include DWC 60 form and Explanations of Benefits. Position summary (Table of Disputed Services) states, "Carrier continued to deny payment for treatment though it contradicted their own IME Doctor and treating doctor opinions. On several occasions the carrier only forwarded limited documentation to their own peer review doctors rendering their opinions both inaccurate and incomplete."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include DWC 60 form, Explanations of Benefits and CMS 1500's. Position Summary (Table of Disputed Services) states: Per the TWCC-62: Payment has been denied as carrier deemed treatment and services medically unreasonable/unnecessary based on a peer review, or based on Forte's Physician Bill Review. No additional reimbursement allowed after review of an appeal/reconsideration."

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)
7-16-04 – 2-3-05	CPT codes 97110, 97112, 99213, 99214 97032, 99212, 97140	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0

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.

Based on review of the disputed issues within the request, the 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.

Regarding CPT code 99080-73 on 13 dates of service: The carrier denied this service with a "V" or a "W9" for unnecessary medical treatment based on a peer review; however, the DWC-73 is a required report per Rule 129.5 and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter; Recommend reimbursement of \$195.00 (\$15.00 X 13 DOS).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, Rule 129.5 and 134.202(c)(1).

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 for the services involved in this dispute in the amount of \$195.00. 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

11-22-05

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.



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NOTICE OF INDEPENDENT REVIEW DECISION

October 24, 2005

Program Administrator
Medical Review Division
Division of Workers Compensation
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Claim #: _____
Injured Worker: _____
MDR Tracking #: M5-05-2957-01
IRO Certificate #: IRO4326

TMF Health Quality Institute (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Division of Workers' Compensation (DWC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. TMF's health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient sustained a work-related injury on ____ when she injured her lower back while trying to lift a large patient off of the floor. Treatment has included spinal injections and chiropractic care.

Requested Service(s)

Therapeutic exercises, neuromuscular re-education, office visits (99213, 99214), electrical stimulation, office visits (99212), and manual therapy technique provided from 07/16/2004 thru 02/03/2005.

Decision

It is determined that the therapeutic exercises, neuromuscular re-education, office visits (99213,99214), electrical stimulation, office visits (99212), and manual therapy technique provided from 07/16/2004 thru 02/03/2005 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The *Guidelines for Chiropractic Quality assurance and Practice Parameters* Chapter 8 under "Failure to Meet Treatment/Care Objectives" state, "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." The American College of Occupational and Environmental Medicine (ACOEM) Guidelines state that if treatment does not bring improvement in three to four weeks, it should be stopped and the patient reevaluated. Based on those guidelines, the initial 4 weeks of treatment from 06/17/2004 thru 07/12/2004 was medically indicated. However, the medical necessity for all treatment after 07/12/2004 is without support.

Expectation of improvement in a patient's condition should be established based on success of that treatment. Continued treatment should improve the patient's condition and initiate restoration of function. If the treatment does not produce positive results, it is not reasonable to continue the same course of treatment. In this case, there is no documentation of objective of functional improvement in this patient's condition and no evidence of a change of treatment plan to justify continued treatment in the absence of positive response to the previous treatment.

The medical records submitted failed to substantiate that the disputed services fulfilled statutory requirements for medical necessity since the patient obtained no relief, promotion of recovery did not occur, and there was

no

enhancement of the employee's ability to return to or retain employment. Specifically, the patient's pain rating was 6/10 on 06/18/2004 at the initiation of treatment, 8/10 on 07/12/2004 after 4 weeks of treatment, and 7/10 on 12/29/2004 near the end of the disputed treatment. Moreover, the patient's cervical ranges of motion dramatically decreased from the time of the 06/17/2004 initial examination until the 02/03/2005 examination (reported in the 03/17/2005 carrier review) at the termination of the disputed treatment.

Specifically in regard to the office visits and based on CPT, there is no support for the medical necessity for the high level of E/M service (99212, 99213, and 99214) on most every date of service during and established treatment plan.

Specifically in regard to manual therapy technique (97140), it is unknown what treatment was performed under the umbrella of services represented by this code. Again, according to CPT, this service might represent manual traction, myofascial release, joint mobilization, or other services. Therefore, it is incumbent upon the provider to detail which specific service was performed when this code is reported. Since the records did not mention the particular service that was provided on any of the dates of service that 97140 appeared, its medical necessity is not supported.

Specifically in regard to the therapeutic exercises (97110), active therapy can be performed in a clinic one-on-one, in a clinic in group, at a gym, or at home. A home exercise program is preferable because the patient can perform them on a daily basis. On the most basic level, the provider has failed to establish why the continuing services were required to be performed one-on-one when current medical literature states, "... there is no strong evidence for the effectiveness of supervised training as compared to home exercises." Osteol 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.

Specifically in regard to the neuromuscular reeducation services (97112), there was nothing in either the diagnosis or the physical examination findings on this patient demonstrated the type of neuropathology that would necessitate the application of this service. According to a Medicare Medical Policy Bulletin, "This therapeutic procedure is provided to improve balance, coordination, kinesthetic sense, posture, motor skill, and proprioception. Neuromuscular reeducation may be reasonable and necessary for impairments which affect the body's neuromuscular system (e.g., poor static or dynamic sitting/standing balance, loss of gross and fine motor coordination, hypo/hypertonicity). The documentation in the medical records must clearly identify the need for these treatments." In this case, the documentation failed to fulfill these requirements, rendering the performance of this service medically unnecessary.

Sincerely,

A handwritten signature in black ink that reads "Gordon B. Strom, Jr." The signature is written in a cursive, somewhat stylized font.

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:dm

Attachment

Information Submitted to TMF for Review

Patient Name: ____

Tracking #: M5-05-2957-01

Information Submitted by Requestor:

- TWCC 60
- Doctor notes
- IMF request
- IMF rating
- Pain management notes
- Diagnostics

Information Submitted by Respondent:

- Notice of UR findings
- MD and DC letters
- Denial notices
- Designated doctor evaluations
- Pain management notes
- FCE
- Follow-up evaluations