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, Texas 77375	MDR Tracking No.: M5-05-3298-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Dallas Fire Insurance Company Box 17	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: TWCC-60 package and explanations of benefits
POSITION SUMMARY: "Carrier refuses to acknowledge recommendations of TWCC DDE Dr. Olin".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to TWCC-60 package and explanations of benefits
POSITION SUMMARY: "There simply is no medical documentation to substantiate the medical necessity for the treatments provided by Requestor. In conclusion, the Requestor should not be entitled to any reimbursement for the disputed treatments or services as they failed to provide any documentation to support that the chiropractor is a hand specialist and need the amount of therapy provided".

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
09-07-04 to 04-26-05	99212, 99213, 99214, 97110, 97112 and 97140	☐ Yes ☒ No	$0.00
		☐ Yes ☐ No	

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 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 10-10-05, 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 99080-73 dates of service 09-15-04, 10-04-04, 10-15-04, 11-01-04, 12-03-04, 12-23-04, 01-21-05, 02-07-05, 03-11-05, 04-01-05 and 04-26-05 denied with a "V" (medical treatment not necessary). Per Rule 129.5 the TWCC-73 is a required report which is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. Reimbursement is recommended in the amount of **$165.00 ($15.00 X 11 DOS).**

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and Rule 129.5

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 $165.00. 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. In addition, the Division finds that the requestor was not the prevailing party and is not entitled to a refund of the IRO fee.

Ordered by:

		10-24-05
Authorized Signature		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.

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

TDI-WC Case Number:	
MDR Tracking Number:	M5-05-3298-01
Name of Patient:	___
Name of URA/Payer:	David M. Griffith, DC
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	David Griffith, DC

October 5, 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 the Division of Workers' Compensation 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: Division of Workers' Compensation

CLINICAL HISTORY
Documents Reviewed Included the Following:

1. Correspondence, examination and treatment records from the provider
2. Correspondence from the carrier
3. Carrier Review
4. Designated Doctor report
5. Physical Performance Examinations
6. EMG/NCV Report
7. EOBs
8. Work Hardening Assessment Psychosocial History
9. Diagnostic Imaging Reports
10. Reports from Orthopedic Pain Management, P.A.

The claimant underwent surgery and physical medicine treatments after sustaining injury on ___ when his right hand was injected with a large amount of hydraulic fluid.

REQUESTED SERVICE(S)
Medical necessity of office visits (99212, 99213, 99214), therapeutic exercises (97110), neuromuscular re-education (97112), and manual therapy technique (97140) from 09/07/04 through 04/26/05.

DECISION
Denied.

RATIONALE/BASIS FOR DECISION
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) Home care programs should be initiated near the beginning of care, include ongoing assessments of compliance and result in fading treatment frequency. (B) 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. (C)

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. In this case, there is 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.

No treatment records were available for review during the time period immediately preceding the treatment in question. Therefore, it is unknown what kinds of therapies and/or treatments had been attempted, what was beneficial and what was not, and were the disputed treatments different or more of the same? Without medical treatment records that answer those questions, there is less than sufficient documentation to support the medical necessity of the disputed treatment.

The records also fail to substantiate that the disputed services fulfilled statutory requirements 1 for medical necessity since the patient obtained little relief, promotion of recovery was not accomplished and there was no enhancement of the employee's ability to return to or retain employment. While the designated doctor opined on 10/12/04 that further physical therapy would be appropriate, there is no support for continuing therapy that had been unsuccessful. The claimant's lack of response is documented by the decreased right wrist ranges of motion from the 08/18/04 examination to the designated doctor examination on 10/12/04.

Specifically in regard to the office visits and based on CPT 2, there is no support for the medical necessity for the high level of E/M service (99212, 99213 and 99214) on most every visit during an established treatment plan.

In regard to the neuromuscular reeducation services (97112), there was nothing in either the diagnosis or the physical examination findings on this patient that demonstrated the type of neuropathology that would necessitate the application of this service. According to a Medicare Medical Policy Bulletin 3, "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.

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1 Texas Labor Code 408.021
2 *CPT 2004: Physician's Current Procedural Terminology, Fourth Edition, Revised.* (American Medical Association, Chicago, IL 1999),
3 HGSA Medicare Medical Policy Bulletin, Physical Therapy Rehabilitation Services, original policy effective date 04/01/1993 (Y-1B)

With regard to manual therapy technique (97140), it is unclear precisely what was performed under the umbrella of services represented by this code. Again, according to CPT 4, this service might represent manual traction, joint mobilization, myofascial release, or a number of other services. Therefore, it is incumbent upon the provider to specify which specific service was performed when this code is reported. Since the records were devoid of any mention of the particular service that was provided on any of the various dates of service that 97140 appeared, its medical necessity is without support.

And finally, in regard to the therapeutic exercises (97110), active therapy can be performed in a clinic one-on-one, in a clinic in a group, at a gym or at home with the least costly of these options being a home program. A home exercise program is also 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." 5 The VAS pain improvements obtained during the disputed time period would have likely also been achieved through the passage of time and the performance of a home program.

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4 *CPT 2004: Physician's Current Procedural Terminology, Fourth Edition, Revised*. (American Medical Association, Chicago, IL 1999),

5 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.