



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: Pain and Recovery Clinic North % Bose Consulting, L. L. C. P. O. Box 550496 Houston, Texas 77255	MDR Tracking No.: M5-06-0025-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Liberty Mutual Fire Insurance, Box 28	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include DWC-60 form, Explanations of Benefits, medical documentation and CMS 1500's. Position Summary states, "Treatment for the claimant was medically reasonable and necessary. We are requesting reimbursement for all disputed dates of services."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the MR100 letter and the Explanations of Benefits. No position summary was received.

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)
10-20-04 – 2-7-05	CPT codes 99212, 97110, 97112, 97140 and 97032	<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.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308

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 additional reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

11-22-05

Authorized Signature

Typed Name

Date of Findings and Decision

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.

NOTICE OF INDEPENDENT REVIEW DECISION

November 4, 2005

Amended Letter: November 18, 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 #: M5-06-0025-01
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, that provider 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 carrier health care providers who reviewed the case for decision before referral to the IRO. 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 he was carrying a treadmill up the staircase when the treadmill slipped and

the patient fell backwards four steps. This resulted in immediate pain in his lower back radiating into his right leg. A portion of the patient's treatment included chiropractic care.

Requested Service(s)

Therapeutic exercises, office visits, neuromuscular reeducation, manual therapy technique, and electrical stimulation provided from 10/20/2004 through 02/07/2005.

Decision

It is determined that the therapeutic exercises, office visits, neuromuscular reeducation, manual therapy technique, and electrical stimulation provided from 10/20/2004 through 02/07/2005 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The medical record documentation does not adequately clinically correlate the patient's symptomatology with either the lumbar MRI (dated 09/20/2004) or the electro-diagnostic findings (dated 10/28/2004). Specifically, while the records repeatedly documented right-sided lower back pain and sciatica (with right foot numbness), the aforementioned diagnostic tests related significant finding to the patient's left side.

Physical medicine treatment requires ongoing assessment of a patient's response to prior treatment and modification of treatment activities to effect additional gains in function. Continuation of an unchanging treatment plan, performance of activities that can be performed as a home exercise program and/or modalities that provide the same effects as those that can be self applied are not indicated. Services that do not require "hands-on care" or supervision of a health care provider are not considered medically necessary services even if the services were performed by a health care provider.

Therapeutic exercises (97110) may 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 not established why it was still necessary for supervised, one-on-one therapeutic exercises during this time frame, particularly when current medical literature states, "...there is no strong evidence for the effectiveness of supervised training as compared to home exercises." ¹ The medical record documentation additionally substantiated that the patient was already safely participating in a group exercise regimen by the dates of service in dispute. Therefore, absent any documentation supporting the medical rationale for a continued supervised exercise protocol after 10/20/2004, it was not supported as necessary.

With regard to the established patient office visits (99212), nothing in either the diagnosis in this case or the medical records supplied supported the medical necessity for performing this level Evaluation and Management (E/M) service at such a frequency, and particularly not during an already-established treatment plan (as defined by CPT²).

With regard to the neuromuscular reeducation services (97112), there was also 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 Bulletin³, "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 medical record documentation 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.

With regard to the attended electrical stimulation (97032) and manual therapy techniques (97140), although it was the required medical doctor's opinion (report dated 01/03/2005) as well as the designated doctor's opinion (report dated 04/01/2005) that the patient required additional treatment, review of the treating doctor's notes revealed that this case failed to meet the statutory requirements⁴ for medical necessity and are therefore not medically necessary. Specifically, the TWCC-73s provided on this patient revealed that he remained on temporary total disability throughout the date range in question; furthermore, subjective improvement was inadequately documented or supported in either the daily or reevaluation records; and more importantly, the medical records were devoid of documented objective functional improvement.

As an example of this, lumbar range of motion was recorded on the initial visit of 11/02/2004 as "flexion 'WNL,' extension at 20" (with no mention of either right or left lateral bending); but, on the reevaluation dated 01/31/2005, lumbar flexion had decreased to 56,

¹ 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.

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)

⁴ Texas Labor Code 408.021

extension had decreased to 18, right lateral bending was at 10 and left lateral bending was at 15. While it is understood that 01/31/2005 was only 4 days following the 3rd injection, the next reevaluation, dated 03/21/2005 – after another 4 weeks of the same post-injection therapy – range of motion had further worsened to flexion of only 55, extension of only 10, left lateral bending of only 10, and right lateral bending of only 8 (all number in degrees).

As a result, the treatment in dispute failed to fulfill the requirements of the Texas Labor Code, since it was not documented that the patient obtained relief from the treatment provided, promotion of recovery was not accomplished, and there was no enhancement of the employee's ability to return to employment.

This decision by the IRO is deemed to be a DWC decision and order.

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.

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for hearing and a **copy of this decision** must be sent to: Chief Clerk of Proceedings/Appeals Clerk, Texas Department of Insurance, Division of Workers' Compensation, P.O. Box 17787, Austin, Texas, 78744, Fax: 512-804-4011.

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

Sincerely,

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

GBS:dm

Attachment

Information Submitted to TMF for Review

Patient Name:

Tracking #: M5-06-0025-01

Information Submitted by Requestor:

- **Progress Notes**

Information Submitted by Respondent:

- **Position statement**
- **MRI**
- **EMG**
- **Medical records**