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:	MDR Tracking No.: M5-06-0057-01
Richard Stephenson, D. C. 322 North Main St. Bryan, TX 77803	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
Liberty Mutual Fire Insurance, Box 28	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included DWC 60 form, Explanations of Benefits, medical documentation and CMS 1500's. Position summary states, "The patient was treated with conservative care in an attempt to reduce pain, enhance her ability to retain gainful employment and to promote recovery. The patient was at a disadvantage compared to her pre-injury status when performing normal job functions as a juvenile corrections office."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included DWC 60 form and Explanations of Benefits. Position summary states, "We base our payments on the Texas Fee Guidelines and the Texas Workers' Compensation Commission Acts and Rules."

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)
9-24-04 – 1-10-05	CPT codes 99213, 97024, 97124, 97530, 97116,	☐ Yes ☒ 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.

Dates of service 9-24-05, 10-15-04 and 1-10-05 were withdrawn by the requestor in letters dated 9-29-05 and 10-10-05. They will not be a part of this review.

Per Rule 133.307 (e)(2)(A) a copy of all medical bills as originally submitted to the carrier for reconsideration in accordance with Rule 133.307 (e)(2)(A) must be submitted to the Division. No bill was submitted for date of service 12-31-04. These services will not be a part of this review.

On 10-11-05 the insurance carrier submitted EOB's showing that the DWC-73 reports on 10-29-04 and 11-12-04 were paid by the carrier.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and Rules 133.307 (e)(2)(A) and 133.307 (e)(2)(A)

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:

		11-15-05
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.

October 26, 2005

TDI, Division of Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-05-0057-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: IRO 5055

Dear Ms. ___:

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 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 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 certified in chiropractic, and is currently on the DWC Approved Doctor List.

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.

Sincerely,

Gilbert Prud'homme
General Counsel
GP:dd

REVIEWER'S REPORT
M5-05-0057-01

Information Provided for Review:
DWC-60, Table of Disputed Services, EOB's
Information provided by Requestor:
Office Notes 08/10/04 – 03/31/05
PT Notes 08/11/04 – 07/05/05
Functional Capacity Test 10/13/04

Radiology 08/23/04
Information provided by Respondent:
Designated Reviews
Physical Medicine:
Office Notes 09/14/04 – 08/09/05

Clinical History:
Patient underwent diagnostic imaging and physical medicine treatments after sustaining injury to his lumbar spine on ___ when he was pushing a trolley loaded 500-600 pounds of chicken.

Disputed Services:
99213 office visits, 97024 diathermy, 97124 massage, 97530 therapeutic activities, 97116 gait training from 09/24/04 through 01/10/05.

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

Rationale:
The *Guidelines for Chiropractic Quality Assurance and Practice Parameters* 1 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." The ACOEM Guidelines 2 that if treatment does not bring improvement in three to four weeks, it should be stopped and the patient reevaluated. Therefore, there was support for the initial 4 weeks of treatment that ended prior to the disputed treatment.

However, for treatment after that time to be medically necessary, the frequency, type and duration of services must be reasonable and consistent with the standards of the health care community. General expectations include: (A) 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; (B) supporting documentation for additional treatment must be furnished when exceptional factors or extenuating circumstances are present; and (C) evidence of objective functional improvement is essential to establish reasonableness and medical necessity of treatment. In this case, there is no documentation of objective or functional improvement in this patient's condition that would justify additional treatment.

In general, most computerized documentation, regardless of the software used, fails to provide individualized information necessary for reimbursement. The Center for Medicare and Medicare Service (CMS) has stated, "Documentation should detail the specific elements of the chiropractic service for this particular patient on this day of service. It should be clear from the documentation why the service was necessary that day. Services supported by repetitive entries lacking encounter specific information will be denied." In this case, there is insufficient documentation to support the medical necessity for the treatment in question since the computer-generated daily progress notes were essentially identical for each date of service.

While the provider's notes on most every date state, "my documentation satisfies without limit the following bases of medical necessity as set forth in Texas Labor Code, Section 408.021(a)…" that was not accomplished. In fact, the submitted records failed to substantiate or document that the patient obtained relief, that promotion of recovery was accomplished or that there was an enhancement of the employee to return to or retain employment as a result of the disputed treatment. Specifically, the patient's pain was rated at "3" on 09/24/04 at the initiation of the disputed treatment and "4" at the termination of treatment on 01/10/05. Moreover, the claimant's right SLR measurement was 64 degrees on 08/10/04 but had regressed to 48/49/48 degrees when next recorded on 03/31/05. The claimant's left SLR measurement was 54 degrees on 08/10/04 but had regressed to 44/42/40 degrees when next recorded on 03/31/05. Therefore, statutory requirements3 for medical necessity were not met.

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1 Haldeman, S; Chapman-Smith, D; Petersen, D *Guidelines for Chiropractic Quality Assurance and Practice Parameters,* Aspen Publishers, Inc.
2 *ACOEM Occupational Medicine Practice Guidelines: Evaluation and Management of Common Health Problems and Functional Recovery in Workers, 2nd Edition*, p. 299.
3 Texas Labor Code 408.021

And finally, the medical records submitted fail to document that chiropractic spinal adjustments were performed at any time. According to the AHCPR4 guidelines, spinal manipulation was the only recommended treatment that could relieve symptoms, increase function and hasten recovery for adults suffering from acute low back pain; the British Medical Journal 5 reported that spinal manipulation combined with exercise yielded the greatest benefit; and JMPT 6 reported that spinal manipulation may be the only treatment modality offering broad and significant long-term benefit for patients with chronic spinal pain syndromes. Based on those findings, this reviewer is perplexed why a doctor of chiropractic would withhold this recommended treatment while performing a host of other non-recommended therapies. Since the treating doctor never attempted a proper regimen7 of this recommended form of treatment, it is not surprising that the claimant failed to improve.

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4 Bigos S., Bowyer O., Braen G., et al. Acute Low Back Problems in Adults. Clinical Practice Guideline No. 14. AHCPR Publication No. 95-0642. Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services. December, 1994.

5 *UK Back pain Exercise And Manipulation (UK BEAM) randomised trial*:
Medical Research Council, British Medical Journal (online version) November 2004.

6 Muller, R. Giles, G.F. Long-term Follow-up of a Randomized Clinical Trial Assessing the Efficacy of Medication, Acupuncture, and Spinal Manipulation for Chronic Mechanical Spinal Pain Syndromes. J Manipulative Physiol Ther 2005;28:3-11.

7 Haas M, Groupp E, Kraemer DF. Dose-response for chiropractic care of chronic low back pain. Spine J. 2004 Sep-Oct;4(5):574-83. “There was a positive, clinically important effect of the number of chiropractic treatments for chronic low back pain on pain intensity and disability at 4 weeks. Relief was substantial for patients receiving care 3 to 4 times per week for 3 weeks.”