



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 Dispute

PART I: GENERAL INFORMATION

Type of Requestor: <input checked="" type="checkbox"/> Health Care Provider <input type="checkbox"/> Injured Employee <input type="checkbox"/> Insurance Carrier	
Requestor's Name and Address: Main Rehab & Diagnostics/Administrative Office 3500 Oak Lawn Suite 380 Dallas, Texas 75219	MDR Tracking No.: M5-06-0257-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Netherlands Insurance Company Box 42	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60 dispute package

POSITION SUMMARY: Mr. ___ attended a brief course of treatment with our clinic, followed by a work hardening program, which resulted in a return to work status. Therefore, we believe that these treatments were reasonable and necessary to the treatment of this patient, as they resulted in his return to full capacity of work.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60

POSITION SUMMARY: No position summary submitted by the Respondent

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
11-04-04 to 12-15-04	97110-QU-GP (\$107.06 X 15 DOS) = \$1,605.90 97530-QU-GP (\$36.11 X 15 DOS) = \$541.65	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2,147.55
11-04-04 to 02-07-05	99211-QU, 97150-QU-GP, 97545-WH-CA-QU, 97546-WH-CA-QU and 97750-FC-QU	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
01-17-05	99080-QU	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$24.00

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 the disputed medical necessity issues.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

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

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 \$2,171.55. 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.

Ordered by:

01-09-06

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]

10817 W. Hwy. 71
Phone: 512-288-3300

Austin, Texas 78735
FAX: 512-288-3356

NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISED 1/4/06

TDI-WC Case Number:	
MDR Tracking Number:	M5-06-0257-01
Name of Patient:	_____
Name of URA/Payer:	Main Rehab & Diagnostics
Name of Provider: (ER, Hospital, or Other Facility)	Main Rehab & Diagnostics
Name of Physician: (Treating or Requesting)	Osler Kamath, DC

November 29, 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

Available documentation received and included for review consists of initial and subsequent reports and treatment records from Drs. Hall (DO), Kamath (DC), consulting doctor report from Drs. Ghazali (MD), designated doctor report Dr. Williams (MD) Peer reviews Mike O'Kelley (DC).

Mr. ____, a 54-year-old male, injured his left hand on ____ while working as a landscaper, mowing lawns. He reached down to switch gears on a mower, however reached too far and severed the tips of his left third and fourth digits. The emergency room referred him to Dr. Hall, who cleaned up his fingers and referred him out for OT/PT. A further surgical procedure was required on 9/2/04, consisting of incision and drainage of the open fracture of the left middle finger and ring finger, as well as completion of partial amputation of the distal portion of these fingers with primary closure. Further OT was performed and on further follow-up (9/13/04) the patient was returned to work, continuing PT for further two weeks and told to follow-up p.r.n. with the surgeon.

The patient then changed treating doctor to Osler Kamath (DC) and was evaluated by him on 10/18/04. He was then placed on an extensive course of treatment, consisting of upper extremity range of motion exercises, pegboard and therapeutic exercises. There was progression into work hardening environment on 12/27/04 which essentially continued the same exercises to the hand but with the addition of cardiovascular treadmill work (10 mins), group stretching, floor exercises for the cervical and lumbar spine, and Job simulation.

A second opinion consult was sought from Dr. Ghazali on 12/23/04. Assessment was of proximal interphalangeal joint capsular contraction of the left long and ring fingers with decreased flexor excursion, and left ring finger stenosing synovitis. Plan was for a proximal interphalangeal joint capsulotomy of the left long and ring fingers and possible flexor tenolysis. Recommendation was for CPM and extensive therapy postop, as well as a steroid injection in the left ring finger. It does not appear from the records that any of these procedures were carried out.

The patient was evaluated for designated doctor purposes on 1/27/05 by Dr. Williams. He was given a whole person impairment rating of 8%.

REQUESTED SERVICE(S)

Medical necessity of office visits (99211) therapeutic activities (97530), therapeutic exercises (97110), therapeutic procedures (97150), work hardening (initial, 97545-WH + additional hour, 97546-WH) functional capacity exam (97750-FC), copies of medical records (99080). Dates of service 11/4/04 through 2/7/05.

DECISION

Approve therapeutic exercises (97110) and therapeutic activities (97530) between 11/4/04 and 12/15/04.

Approve copies of medical records for all dates of service.

Deny all other disputed services.

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.

The records for the disputed timeframe are 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 in this timeframe 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.

It is reasonable to expect some form of postoperative rehabilitation, and it does appear that therapeutic interventions were insufficient prior to the patient starting treatment with Dr. Kamath. Range of motion and strength were compromised in this patient as documented on 10/18/04. The patient was treated with range of motion and strengthening exercises, along with therapeutic activities on the pegboard. Clinical guidelines support at least eight weeks of therapy in such a case. There is sufficient evidence that improvement was made with the program. Therapeutic exercises/activities to appear to be reasonable until 12/15/04.

However, there is no information as to what or why group exercises were performed, and how they differed from the documented therapeutic exercises and pegboard activity. There is no medical necessity for group activity (97150) services established in the documentation.

The patient was essentially focused exercise/rehabilitation program. As such, there is no documented requirement for the sequential billing of office visit services. The standard timeframe for reassessment office visit services, according to Medicare guidelines, is once every two or three weeks, however no such "reevaluation/assessment" was performed. There is no medical necessity established here for an office visit service billed on each sequential date of service.

Work hardening involves a multidisciplinary approach and is reserved typically for outliers of the normal patient population, i.e. poor responders to conventional treatment intervention, with significant psychosocial issues and extensive absence from work.

This patient had responded to the previous interventions, did not have "extensive absence from work", there were no clearly identified psychosocial barriers to recovery. There was very little to indicate what was different in the work hardening environment as compared to previous therapy (that related to the injury in question). The patient did not appear to satisfy any of the entry requirements for work hardening program and the work hardening performed has not been established as medically necessary.

References:

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".

CARF Manual for Accrediting Work Hardening Programs

AMA Guides to the Evaluation of Physical Impairment, 4th Edition

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

Liebenson C. Commentary: Rehabilitation and chiropractic practice. JMPT 1996; 19(2):134140

Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that I have no known conflicts of interest between the 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.

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.

Chief Clerk of Proceedings
Division of Workers' Compensation
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell