



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.: M5-06-0266-01
Killeen Rehab Group 5445 La Sierra Drive # 204 Dallas, TX 75231	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:
Liberty Mutual Fire Insurance, Box 28	

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 form, Explanations of Benefits, medical documentation and CMS 1500's. Position summary states, "Based upon results of the patient's initial PPE and Interim PPE medical necessity was established for the physical therapy that was provided."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response and 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)
10-18-04	CPT code 99213	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$61.98
12-20-04 – 12-30-04	CPT code 98940, 97124	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$230.52
12-18-04 – 4-21-05	CPT code 98940, 97124 97110, 97112, 99080-73, 97530, 97032, 99211, 99212, 99213 (except as noted above)	<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 majority of the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$292.50.

Based on review of the disputed issues within the request, the 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 12-07-05 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, 98940 and 97124 on 12-1-04 and 99212 on 12-1-04 and 4-21-05 were denied by the carrier as "X206 – This service is for a condition which is not related to the covered work related injury." However, the respondent did not submit the required DWC 21 report to support this denial. Reimbursement totaling \$145.95 recommended as follows:

CPT code 98940 - \$31.35

CPt code 97124 - \$26.28

CPT code 99212 \$88.32 (\$44.16 X 2 DOS).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 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 \$438.45. 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:

Donna Auby

12-28-05

Authorized Signature

Typed Name

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.

December 14, 2005

TX DEPT OF INS DIV OF WC
AUSTIN, TX 78744-1609

CLAIMANT: ____

EMPLOYEE: ____

POLICY: M5-06-0266-01

CLIENT TRACKING NUMBER: M5-06-0266-01/5278

Medical Review Institute of America (MRIoA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Department of Insurance Division of Workers Compensation has assigned the above mentioned case to MRIoA for independent review in accordance with DWC Rule 133 which provides for medical dispute resolution by an IRO.

MRIoA has performed an independent review of the case in question to determine if the adverse determination was appropriate. In performing this review all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the DWC approved doctor list (ADL). The reviewing provider has no known conflicts of interest existing between 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.

Records Received:

Records Received from the State:

- Notification of IRO assignment, dated 11/10/05 – 1 page
- Texas Department of Insurance Form, dated 11/10/05 – 12 pages
- Explanation of Benefits, dated 12/03/04-05/09/05 – 14 pages

Records Received from Killeen Rehab Group:

- Order for Payment of Independent Review Organization, undated 3 pages
- Texas Department of Insurance Form, dated 10/10/05 – 1 page
- Texas Department of Insurance Form, dated 11/10/05 – 1 page
- Referral Form, dated 10/12/04 – 1 page
- MRI Report, dated 09/08/04 – 1 page
- MRI Report, dated 10/13/04 – 2 pages
- Subsequent Medical Narrative Report, dated 09/14/04 – 8 pages
- Daily Notes Report, dated 07/07/04-09/24/04 – 13 pages
- Independent Medical Evaluation, dated 10/04/04 – 8 pages
- Grip Test Results – 5 pages
- Clinic Notes, dated 06/28/04 – 1 pages
- Work Related Injury Report, dated 07/02/04 – 3 pages
- Daily Notes Report, dated 10/01/04 - 1 page
- Lumbar Daily Rehab Assessment, dated 10/01/04 – 2 pages
- Daily Notes Report, dated 10/08/04 – 2 pages
- Lumbar Daily Rehab Assessment, dated 10/08/04 – 1 page
- Daily Notes Report, dated 10/11/04 – 2 pages
- Texas Workers' Compensation Work Status Report, dated 10/11/04 – 1 page
- Initial Behavioral Medicine Consultation, dated 10/21/04 – 6 pages
- Daily Notes Report, dated 10/06/04 – 2 pages
- Chart Notes, dated 10/13/04 – 2 pages
- Lumbar Daily Rehab Assessment, dated 10/13/04 – 1 page
- Chart Notes, dated 10/15/04 – 2 pages
- Lumbar Daily Rehab Assessment, dated 10/15/04 – 1 page
- Chart Notes, dated 10/18/04 – 2 pages
- Lumbar Daily Rehab Assessment, dated 10/18/04 – 1 page
- Chart Notes, dated 10/20/04 – 2 pages

- Lumbar Daily Rehab Assessment, dated 10/20/04 – 1 page
- Chart Notes, dated 10/21/04 – 2 pages
- Chart Notes, dated 10/22/04 – 2 pages
- Chart Notes, dated 10/25/04-10/26/04 – 7 pages
- Chart Notes, dated 10/27/04-11/29/04 – 16 pages
- Subsequent Medical Narrative Report, dated 10/21/04 – 8 pages
- PPE Report, dated 11/30/04 – 8 pages
- Chart Notes, dated 11/30/04-12/20/04 – 7 pages
- Texas Workers' Compensation Work Status Report, dated 12/20/04 – 1 page
- Chart Notes, dated 12/22/04-03/08/05 – 20 pages
- Subsequent Medical Narrative, dated 11/30/04 – 8 pages
- Chart Notes, dated 02/11/05 – 1 page
- Texas Workers' Compensation Work Status Report, dated 02/11/05 – 1 page
- Chart Notes, dated 02/28/05-04/05/05 – 3 pages
- Texas Workers' Compensation Work Status Report, dated 04/05/05 – 1 page
- Chart Notes, dated 04/12/05-04/05/05 – 1 page

Summary of Treatment/Case History:

The patient is a 40-year-old male moving warehouseman who, on ____, performed some heavy lifting and pushing when he began experiencing lower back and mid-back pain. He was first seen at a medical clinic, prescribed bed rest, medication, and stretching exercises. He was returned to work with specific restrictions on 7/2/04 that were to last for 2 weeks.

He then presented himself to a doctor of chiropractic on 7/7/04 who began a regimen of chiropractic care to include spinal manipulation, physical therapy and rehabilitation. A trial of epidural steroid injections, followed by post-injection therapy, was then provided.

Questions for Review:

1. Items in dispute: were the chiropractic manipulations (#98940), massage (#97124), therapeutic exercises (#97110), neuromuscular re-education (#97112, #99080-73 (DWC required report), therapeutic activities (#97530) electrical stimulation (#97032), and office visits (#99211, #99212, #99213) from 10/18/04 to 4/21/05 medically necessary?

Explanation of Findings:

Question 1: Were the chiropractic manipulations (#98940), massage (#97124), therapeutic exercises (#97110), neuromuscular re-education (#97112, #99080-73 (DWC required report), therapeutic activities (#97530) electrical stimulation (#97032), and office visits (#99211, #99212, #99213) from 10/18/04 to 4/21/05 medically necessary?

The office visit, level III (#99213) for date of service 10/18/04 is approved; the chiropractic manipulative therapy, spinal 1-2 areas (#98940) and the massage therapy (#97124) *only* for dates of service 12/20/04 through and including 12/30/04 are also approved. All other services, including those performed from 12/20/04 through 12/30/04, are denied.

In this case, the medical records revealed that – after attempts at other conservative treatments had yielded less than desirable results – the patient underwent a clinical trial of epidural steroid injections beginning on 12/16/04, followed by a 6-visit post-injection therapeutic protocol. In addition, the records adequately documented the presence of muscular spasticity and pain. Therefore, the medical necessity for spinal manipulation as well as massage post-injection for those dates of service was supported. Furthermore, the records indicated that on 10/18/04, the treating doctor spent additional “face-to-face” time with the patient discussing his MRI findings, so this particular office visit was also supported as medically necessary.

But in terms of the remaining office visits (#99211, #99212 & #99213) throughout the dates of service in question, the medical records were devoid of any specific Evaluation and Management (E/M) service provided that would necessitate reporting this separately. In addition, per CPT, nothing in either the medical records or the patient’s diagnosis supported the medical necessity of reporting a separate E/M service on each and every patient encounter, and particularly not during an already-established treatment plan.

Insofar as the neuromuscular reeducation services (#97112) were concerned, 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, “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.

Referable to the therapeutic exercises (#97110) and therapeutic activities (#97530), 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. In fact, 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.

But in this case, the provider has failed to establish why the continuing services were still required to be performed one-on-one, particularly when current medical literature states, "...there is no strong evidence for the effectiveness of supervised training as compared to home exercises." And certainly after 3 months of monitored instruction (the records reveal that this patient was started on therapeutic exercises on 7/19/04), the claimant should have certainly been able to safely perform the exercises on his own. Any gains obtained in this time period would have likely been achieved through performance of a home program.

In terms of the electrical stimulation, attended (#97032), these were performed on 10/22/04 and on 10/25/04, a full 4 months post-injury. Nothing in the records for either of those dates of service documented either an aggravation or new injury that would warrant the application of this type of modality so far removed from the date of injury. In fact, the NASS Guidelines state that passive interventions are indicated during the first 8 weeks only, "if [they are] clinically indicated and not previously unsuccessful." Therefore, the performance of this therapy was not supported as medically necessary.

Conclusion:

The office visit, level III (#99213) for date of service 10/18/04 is approved; the chiropractic manipulative therapy, spinal 1-2 areas (#98940) and the massage therapy (#97124) *only* for dates of service 12/20/04 through and including 12/30/04 are also approved. All other services, including those performed from 12/20/04 through 12/30/04, are denied.

References Used in Support of Decision:

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

HGSA Medicare Medical Policy Bulletin, Physical Therapy Rehabilitation Services, original policy effective date 04/01/1993 (Y-1B)

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.

North American Spine Society phase III clinical guidelines for multidisciplinary spine care specialists. 2000

This review was provided by a chiropractor who is licensed in Texas, certified by the National Board of Chiropractic Examiners, is a member of the American Chiropractic Association and has several years of licensing board experience. This reviewer has given numerous presentations with their field of specialty. This reviewer has been in continuous active practice for over twenty years.

MRIOA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the treating provider, payor and/or URA, patient and the DWC.

It is the policy of Medical Review Institute of America to keep the names of its reviewing physicians confidential. Accordingly, the identity of the reviewing physician will only be released as required by state or federal regulations. If release of the review to a third party, including an insured and/or provider, is necessary, all applicable state and federal regulations must be followed.

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The written opinions provided by MRIOA represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to MRIOA for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Medical Review Institute of America assumes no liability for the opinions of its contracted physicians and/or clinician advisors. The health plan, organization or other party authorizing this case review agrees to hold MRIOA harmless for any and all claims which may arise as a result of this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

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Case Analyst: Stephanie R ext 537