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: (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address: Eric A. VanderWerff, D. C. 615 N. O'Connor Rd. Suite 12 Irving, TX 75061	MDR Tracking No.: M5-06-0506-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Liberty Insurance Corporation, Box 28	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 package. Position summary states, "All the medical services provided to the patient were applied to the compensable injury area and were medically necessary."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response. Position summary states, "Denied by peer review."

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)
11-1-04, 11-8-04, 11-10-04, 11-15-04, 11-17-04, 11-22-04, 11-24-04, 11-29-04, 12-01-04, 12-06-04, 12-08-04, 12-13-04, 12-15-04	CPT code 97150 ($22.60 X 13 DOS)	☒ **Yes** ☐ **No**	$1,175.20
See dates above.	CPT code 98940 ($33.61 X 13 DOS)	☒ **Yes** ☐ **No**	$436.93
See dates above.	CPT code 98943 (DOP code)	☒ **Yes** ☐ **No**	DOP
See dates above.	CPT code G0283 ($14.41 X 13 DOS)	☒ **Yes** ☐ **No**	$187.33
11-2-04, 11-9-04, 11-11-04, 11-16-04, 11-23-04, 12-07-04, 12-14-04, 12-16-04,	CPT codes 97150, 98940, 98943, G0283	☐ **Yes** ☒ **No**	0
1-10-05 – 5-19-05	CPT codes 97150, 98940, 98943, G0283	☐ **Yes** ☒ **No**	0
11-1-04 – 5-19-05	CPT code 97140	☐ **Yes** ☒ **No**	0
	Grand Total		$1,799.46 plus DOP amount

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.

In accordance with Rule 133.308 (e) dates of service 10-27-04 and 10-28-04 were not timely filed and will not be a part of this review.

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 $1,799.46 plus DOP amounts.

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 requestor is not due a refund of the IRO fee. The Division has determined that the requestor is entitled to additional reimbursement in the amount of $1,799.46 plus DOP amount. 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	3-6-06
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.

NOTICE OF INDEPENDENT REVIEW

NAME OF PATIENT: ___
IRO CASE NUMBER: M5-06-0506-01
NAME OF REQUESTOR: Eric Vanderwerff, D.C.
NAME OF PROVIDER: Eric Vanderwerff, D.C.
REVIEWED BY: Licensed by the Texas State Board of Chiropractic Examiners
IRO CERTIFICATION NO: IRO 5288
DATE OF REPORT: 02/08/06 (REVISED 02/09/06 & 03/02/06)

Dear Dr. Vanderwerff:

Professional Associates has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO) (#IRO5288). Texas Insurance Code Article 21.58C, effective September 1, 1997, allows a patient, in the event of a life-threatening condition or after having completed the utilization review agent's internal process, to appeal an adverse determination by requesting an independent review by an IRO.

In accordance with the requirement for TDI-Division of Workers' Compensation (DWC) to randomly assign cases to IROs, DWC has assigned your case to Professional Associates for an independent review. The reviewing physician selected has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, the reviewing physician reviewed 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. determination, and any documentation and written information submitted in support of the appeal.

This case was reviewed by a physician reviewer who is Licensed in the area of Chiropractics and is currently listed on the DWC Approved Doctor List.

I am the Secretary and General Counsel of Professional Associates and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him the provider, 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.

REVIEWER REPORT

Information Provided for Review:

Chiropractic treatment with Eric A. VanderWerff, D.C. dated 10/27/04, 10/28/04, 11/01/04, 11/02/04, 11/08/04, 11/09/04, 11/10/04, 11/11/04, 11/15/04, 11/16/04, 11/17/04, 11/22/04, 11/23/04, 11/24/04, 11/29/04, 12/01/04, 12/02/04, 12/06/04, 12/07/04, 12/08/04, 12/13/04, 12/14/04, 12/15/04, 12/16/04, 01/06/05, 01/10/05, 01/11/05, 01/12/05, 01/13/05, 01/17/05, 01/18/05, 01/19/05, 01/20/05, 01/24/05, 01/25/05, 01/26/05, 01/27/05, 01/31/05, 02/02/05, 02/03/05, 02/07/05, 02/08/05, 02/09/05, 02/14/05, 02/15/05, 02/16/05, 02/17/05, 02/21/05, 02/22/05, 02/23/05, 02/24/05, 02/28/05, 03/02/05, 03/03/05, 03/07/05, 03/09/05, 03/10/05, 03/14/05, 03/16/05, 03/17/05, 03/21/05, 03/23/05, 03/24/05, 03/29/05, 03/30/05, 04/04/05, 04/06/05, 04/07/05, 04/11/05, 04/14/05, 04/19/05, 04/21/05, 04/25/05, 04/27/05, 04/28/05, 05/09/05, 05/12/05, 05/16/05, 05/18/05, and 05/19/05
Evaluations with Dr. VanderWerff dated 10/27/04, 10/29/04, and 01/06/05
An MRI of the right shoulder interpreted by Richard B. Thropp, M.D. dated 01/12/05
A behavioral health evaluation with Sandra K. Young-Whigham, L.C.S.W. dated 01/27/05
Physical Performance Evaluations (PPEs) with Adrian Olivares, D.O. dated 02/09/05, 03/24/05, and 06/27/05
An EMG/NCV study interpreted by Sherine Boyd Reno, M.D. dated 03/10/05
Designated Doctor Evaluations with Harold Marshall, M.D. dated 04/15/05 and 12/28/05
A Required Medical Evaluation (RME) with Dr. Reno dated 07/18/05

Clinical History Summarized:

Chiropractic treatment was performed with Dr. VanderWerff from 10/27/04 through 05/19/05 for a total of 80 sessions. An MRI of the right shoulder interpreted by Dr. Thropp on 01/12/05 revealed mild degenerative arthritic changes of the AC joint. Ms. Young-Whigham recommended a work hardening program on 01/27/05. PPEs with Dr. Olivares on 02/09/05, 03/24/05, and 06/27/05 showed the patient was functioning in the medium physical demand level. An EMG/NCV study interpreted by Dr. Reno on 03/10/05 revealed mild injury to the upper trunk of the brachial plexus. On 04/15/05, Dr. Marshall felt the patient was not at Maximum Medical Improvement (MMI). He recommended completeing the work hardening program and an EMG/NCV study. On 07/18/05, Dr. Reno felt the patient was at MMI with a 6% whole person impairment rating. Dr. Marshall felt the patient was not at MMI as of 12/28/05.

Disputed Services:

Manual therapy techniques, group therapeutic procedures, chiropractic manipulation, and electrical stimulation from 11/01/04 through 05/19/05

Decision:

I partially agree with the requestor. The electrical stimulation, group therapeutic procedures, and chiropractic manipulation would be reasonable and medically necessary from 11/01/04 through 12/27/04, which represented a period of eight weeks. The patient did not treat from 12/17/04 through 12/27/04. Typically for this type of injury only 15 visits in an eight week period would be appropriate. This patient was appropriately seen only 13 times within the eight week period of 11/01/04 through 12/27/04. Consecutive day treatment would not be considered reasonable or medically necessary during this eight week period. Therefore, the patient would not have needed to be seen on 11/02/04, 11/09/04, 11/11/04, 11/16/04, 11/23/04, 12/07/04, 12/14/04, and on 12/16/04 as these were consecutive day care, which would not have been necessary. I disagree with the requestor in regard to the use of any manual therapy technique between 11/01/04 and 12/16/04 and all treatment after 12/16/04 through 05/19/05 would not be reasonable or necessary.

Rationale/Basis for Decision:

Based upon a review of the records provided, in my opinion, the documentation did not support treatment after 12/16/04 as reasonable or medically necessary as related to the injury of ___. According to the documentation, this patient was injured when he was grabbed by the right arm, pulling it behind his back, and he injured his right shoulder and mid back. The attending chiropractor's diagnoses included (831.04) dislocation of the acromioclavicular joint, (839.21) an ill-defined dislocation of a thoracic spine (subluxation), (726.0) adhesive capsulitis, (728.85) muscle spasms, and (718.81) shoulder joint derangement. It has been noted those diagnoses have not been supported by clinical objective findings. In addition, records indicated that the patient was not seen until 23 days after the date of the initial injury and was treated from 10/27/04 through 12/16/04. No treatment occurred between 12/17/04 and 01/06/05. Treatment once again resumed, beginning 01/06/05 through 05/19/05, which constituted an additional 56 visits. Overall during this timeframe, the patient was treated for a total of approximately 80 visits. Based upon the guidelines set forth in Chapter 3, Chapter 8, and Chapter 9 of the

ACOEM Guidelines, which pertain to the initial approach to treatment, treatment of neck and upper back complaints, and treatment of shoulder complaints, it was noted that specific recommendations are made on the use of both manipulative and physical medicine modalities. On Page 48, it was noted that from the acute to subacute phases, for a period of two weeks or less, physicians could use passive modalities such as the application of heat and cold for temporary amelioration of symptoms and to facilitate mobilization and graded exercises, although not for long term use, transcutaneous galvanic and electrical stimulation to keep symptoms at bay temporarily, diminishing pain long enough so the patient begins to mobilize. Little evidence suggested the effectiveness of other passive modalities. It continued by stating that manipulative therapy on appropriately selected patients may be effective in aiding recovery as opposed to promoting or providing merely short-term comfort. On Page 173, it stated there was no high grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities. It also stated that in regard to physical modalities, there was insufficient scientific testing to determine the effectiveness, but they may have some value in the short-term, if used in conjunction with a program of functional restoration.

In reviewing the daily progress notes that have been submitted for review, it has been noted that these records have not been maintained in a commonly accepted medical/chiropractic format and do not set forth the subjective complaints, objective findings, assessment, and plan or prognosis in a descriptive or narrative format on each visit. The form of record keeping utilized did not conform to the generally accepted standard of care for documentation of daily patient encounters and did not support the medical necessity of all the services provided, the frequency of care, and particularly the length of care.

In regard to the specific modalities and procedures utilized, it was noted that there has been no documentation indicating the areas being treated, the length of time of each treatment, the setting or frequency utilized in the treatment, who actually performed the treatment, and what was the patient's overall response to each treatment.

The rationale for the opinions stated in this report are based on clinical experience and standards of care in the area as well as broadly accepted literature which includes numerous textbooks, professional journals, nationally recognized treatment guidelines and peer consensus.

This review was conducted on the basis of medical and administrative records provided with the assumption that the material is true and correct.

This decision by the reviewing physician consulting for Professional Associates is deemed to be a Division decision and order.

YOUR RIGHT TO REQUEST A HEARING

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. A request for a hearing should be faxed to 512-804-4011 or sent to:

Chief Clerk of Proceedings/Appeals Clerk
TDI-Division of Workers' Compensation
P. O. Box 17787
Austin, TX 78744

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

I hereby verify that a copy of this Independent Review Organization's decision was sent to DWC via facsimile or U.S. Postal Service on 03/02/06 from the office of Professional Associates.

Sincerely,

_____
Lisa Christian
Secretary/General Counsel