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

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address: Nestor Martinez, D.C. 6660 Airline Drive Houston, TX 77076	MDR Tracking No.: M5-06-0595-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Ace American Insurance Company, Box 15	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include DWC-60 package. Position Summary states, "Attached herewith are two copies of the DWC-60 and documentation in accordance with DWC Rules 133.307 and 133.308. The remainder of the documents will be forwarded to DWC and/or to the IRO upon notice."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC-60 response.

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)
1-14-05 – 4-11-05	99212, 97112, 97110, 97140, 97032	☐ 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.

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:

	Donna Auby	1-30-06
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

January 18, 2006 **Amended Letter: January 26, 2006**

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 #: M5-06-0595-01
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 DWC 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. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and 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 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 29 year old male sustained a work-related injury on ___ when he bent to lift and install a flange and injured his lower back. The patient complained of chronic unremitting lower back and right leg pain. A portion of his treatment included the following services.

Requested Service(s)

(66212) office visits, (97112) neuromuscular re-education, (97110) therapeutic exercises, (97140) manual therapeutic technique, (97032) electrical stimulation, provided from 01/14/2005 through 04/11/2005.

Decision

It is determined that the (66212) office visits, (97112) neuromuscular re-education, (97110) therapeutic exercises, (97140) manual therapeutic technique, (97032) electrical stimulation, provided from 01/14/2005 through 04/11/2005 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

Physical medicine is an accepted part of a rehabilitation program following an injury. However, for medical necessity to be established there must be an expectation of recovery or improvement within a reasonable and generally predictable time period. In addition, the frequency, type and duration of services must be reasonable and consistent with the standards of the health care community. General expectation include: (A) As time progresses, there should be an increase in the active regimen of care, a decrease in the passive regimen of care and a decline in the frequency of care. (B) Home care programs should be initiated near the beginning of care, include ongoing assessments of compliance and result in fading treatment frequency. (C) 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. (D) Supporting documentation for additional treatment must be furnished when exceptional factors or extenuating circumstances are present. (E) Evidence of objective functional improvement is essential to establish reasonableness and medical necessity of treatment. Expectation of improvement in a patient's condition should be established based on success of treatment. Continued treatment is expected to improve the patient's condition and initiate restoration of function. If treatment does not produce the expected positive results, it is not reasonable to continue the course of treatment. In this case, there is no documentation of objective or functional improvement in this patient's condition.

Specifically in regard to the office visits and based on CPT1, there is no support for the medical necessity for the E/M service (99212) on most every visit during an established treatment plan.

Specifically in regard to the neuromuscular re-education services (97112), 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 Bulletin2, "This therapeutic procedure is provided to improve balance, coordination, kinesthetic sense, posture, motor skill, and proprioception. Neuromuscular re-education 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.

Specifically in regard to the therapeutic exercises (97110), active therapy can be performed in a clinic one-on-one, in a clinic 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 failed to establish why the continuing services were required to be performed one-on-one when current medical literature states, "…there is no strong evidence for the effectiveness of supervised training as compared to home exercises."3 Moreover, since the patient had previously undergone a chronic pain management program, it was highly unlikely yet foreseeable that reverting back to active therapy would offer any additional benefit.

Specifically in regard to the electrical stimulation (97032), it is the position of the Texas Chiropractic Association4 that it is beneficial to proceed to the rehabilitation phase (if warranted) as rapidly as possible, and to minimize dependency upon passive forms of treatment/care since studies have shown a clear relationship between prolonged restricted activity and the risk of failure in returning to pre-injury status. The TCA Guidelines also state that the repeated use of acute care measures alone generally fosters chronicity, physician dependence and over-utilization and the repeated use of passive treatment/care tends to promote physician dependence and chronicity. The ACOEM Guidelines5 state that passive modalities such as massage,

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1 *CPT 2004: Physician's Current Procedural Terminology, Fourth Edition, Revised,* (American Medical association, Chicago, Il 1999)
2 HGSA Medicare Medical Policy Bulletin, Physical Therapy Rehabilitation Services, original policy effective date 04/01/1993 (Y-1B)
3 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 conchrane collaboration. Spine. 2003 Feb 1;28(3):209-18
4 Quality Assurance Guidelines, Texas Chiropractic Association.
5 ACOEM *Occupational Medicine Practice Guidelines: Evaluation and Management of Common Health Problems and Functional Recovery in Workers, 2nd Edition,* p. 299

diathermy, TENS units, have no proven efficacy in treating acute low back symptoms and that there is no high-grade scientific evidence to support the effectiveness of passive modalities such as traction, heat/cold application, massage, diathermy, ultrasound, or TENS units for cervical spine conditions. The NASS Guidelines6 state that passive interventions are indicated during the first 8 weeks only "if clinically indicated and not previously unsuccessful." Since the disputed passive treatments in this case failed to meet those parameters since there were rendered well after the 8-week period and had been previously unsuccessful, there is no support for their medical necessity.

More importantly, the records fail to substantiate that the disputed services fulfilled statutory requirements7 for medical necessity since the patient obtained no relief, promotion of recovery was not accomplished and there was no enhancement of the employee's ability to return to or retain 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 that 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,

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

GBS:dm

Attachment

6 North American Spine Society phase III clinical guidelines for multidisciplinary spine care specialist. 2000.
7 Texas Labor Code 408.021

Attachement

Information Submitted to TMF for Review

Patient Name: ___

Tracking Number: M5-06-0595-01

Information Submitted by Requestor:

Information Submitted by Respondent:

- Comprehensive medical analysis
- Medical review letter
- Radiology reports
- PT assessment
- Initial medical report
- Assessment and physical examination
- Office notes
- Ortho consultation
- Operative note
- MMI/Impairment rating
- Letters of medical necessity
- Psychotherapy notes
- Psychological evaluation
- Treatment plan
- Ortho reports
- Progress notes
- Required Medical exam
- Functional capacity examination
- Subsequent medical reports