



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: Summit Rehabilitation Centers 2500 West Freeway # 200 Fort Worth, Texas 76102	MDR Tracking No.: M5-06-0666-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Twin City Fire Insurance Company Box 27	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: Per the table of disputed services "Necessary Treatment"

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No response submitted by Respondent

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
11-29-04 to 01-03-05	97110 (19 units @ \$35.69 per unit = \$678.11) 97110 (2 units @ \$34.93 per unit = \$69.86) 97116 (1 unit @ \$30.59 X 3 DOS = \$91.77)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$839.74
01-06-05 to 07-20-05	97110, 97116, 97140-59, 98940, G0283, 99354, 95833, 96004, 97012, 99213, 97124 and 95851	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00

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.

Per Rule 133.308(e)(1) date of service 11-24-04 was not timely submitted and will therefore not be part of the review. HCPCS Code L0515 date of service 01-24-05 listed on the table of disputed services will not be reviewed as this code is not listed on the 2005 DMEPOS Fee Schedule as a valid code.

Based on review of the disputed issues within the request, the Medical Review Division 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 02-10-06, 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 97110 (1 unit) date of service 01-03-05 denied with denial code "S" (reimbursement is based on balance due from a previously submitted invoice). The carrier has made a payment of \$4.42. Per Rule 133.307(g)(3)(A-F) the requestor submitted documentation supporting the service billed. Additional reimbursement in the amount of **\$30.51 (\$34.93 minus carrier payment of \$4.42)**.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.202(c)(1) and 133.307(g)(3)(A-F)

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 reimbursement in the amount of \$870.25. 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:

03-02-06

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

TDI-WC Case Number:	_____
MDR Tracking Number:	M5-06-0666-01
Name of Patient:	_____
Name of URA/Payer:	Summit Rehab Centers
Name of Provider: (ER, Hospital, or Other Facility)	Summit Rehab Centers
Name of Physician: (Treating or Requesting)	Luz D. Gonzalez, DC

January 17, 2006

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

Documents Reviewed Included the Following:

1. Notification of IRO Assignment, Table of Disputed Services, Carrier EOBs
2. Lumbar spine, cervical spine, and right shoulder MRI reports, dated 12/23/04
3. Upper and lower extremity electrodiagnostic findings and report, dated 1/6/05
4. Computerized range of motion and muscle testing findings (for spine and extremities), multiple dates
5. Referral medical doctor's narrative reports, dated 12/2/04, 12/9/04, 12/16/04, 12/30/04
6. Referral spinal surgeon's narrative reports, dated 5/2/05 and 7/11/05
7. Referral pain management specialist's narrative report, multiple dates
8. Osteopathic report, dated 3/29/05
9. Referral anesthesiologist's report, dated 5/18/05
10. Referral neurosurgeon's report, dated 10/24/05

11. Operative reports for steroid injections, dated 2/10/05, 3/10/05, 7/1/05,
12. "Clinical S.O.A.P. Notes" from the treating doctor, multiple dates
13. Designated doctor examination and TWCC-69 report, dated 11/11/05
14. TWCC-73s, multiple dates
15. "Transportation verification" slips
16. Summary statement of position from provider, dated 1/3/06

Claimant underwent active and passive physical medicine treatments and 3 ESIs after sustaining injury on ____ when he slipped in mud while working on a landscaping project.

REQUESTED SERVICE(S)

Electrical stimulation, unattended (G0283), prolonged service (99354), muscle testing (95833), therapeutic exercises (97110), gait training (97116), manual therapy techniques (97140-59), chiropractic manipulative therapy (98940), range of motion testing (95851), motion analysis (96004), mechanical traction (97012), established patient office visit, level III (99213), and massage (97124) for dates of service 11/29/04 through 7/20/05.

DECISION

All treatments from 11/29/04 through 01/03/05 are approved.

All treatments, procedures and examinations after 01/03/05 are denied.

RATIONALE/BASIS FOR DECISION

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." Therefore, there was support for the treatments rendered during the period from 11/24/04 through 01/03/05.

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 expectations 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 that course of treatment. In this case, there is no documentation of objective or functional improvement in this patient's condition and no evidence of a change of treatment plan to justify additional treatment in the absence of positive response to prior treatment.

Since the provider was a doctor of chiropractic, a change in treatment plan that included a proper regimen² thrust manipulation would have been indicated since according to the AHCP³ guidelines, spinal manipulation was the only recommended treatment that could relieve symptoms, increase function and hasten recovery for adults suffering from

1 Haldeman, S; Chapman-Smith, D; Petersen, D *Guidelines for Chiropractic Quality Assurance and Practice Parameters*, Aspen Publishers, Inc.

2 Haas M, Group 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."

3 Bigos S., Bowyer O., Braen G., et al. Acute Low Back Problems in Adults. Clinical Practice Guideline No. 14. AHCP³ 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.

acute low back pain; the British Medical Journal 4 reported that spinal manipulation combined with exercise yielded the greatest benefit; and JMPT 5 reported that spinal manipulation may be the only treatment modality offering broad and significant long-term benefit for patients with chronic spinal pain syndromes. Moreover, several studies^{6 7 8 9 10 11} have proven the effectiveness of spinal manipulation for patients with cervical spine symptoms and conditions.

Specifically in regard to muscle testing (95833) and based on CPT 12, the description of that code means, "total evaluation of body, including hands." The medical records do not support the medical necessity of this service.

Specifically in regard to motion analysis (96004) and based on CPT 13, the description of that code means, "Physician review and interpretation of comprehensive computer-based motion analysis, dynamic plantar pressure measurements, dynamic surface EMG during walking or other functional activities, and dynamic fine wire EMG with written report." Again, the medical records do not support the medical necessity of this service.

In the final analysis, the records fail to substantiate that the disputed services (after 01/03/05) fulfilled statutory requirements 14 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. In fact, the claimant's pain ratings increased from 4/10 on 12/06/04 to 5/10 on 07/16/05 at the termination of the disputed treatment.

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.

4 *UK Back pain Exercise And Manipulation (UK BEAM) randomised trial:*

Medical Research Council, British Medical Journal (online version) November 2004.

5 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.

6 Hurwitz EL, Morgenstern H, Harber P, Kominski GF, Yu F, Adams AH. A randomized trial of chiropractic manipulation and mobilization for patients with neck pain: clinical outcomes from the UCLA neck-pain study. *Am J Public Health*. 2002 Oct;92(10):1634-41.

7 Hoving JL, Koes BW, de Vet HC, van der Windt DA, Assendelft WJ, van Mameren H, Deville WL, Pool JJ, Scholten RJ, Bouter LM. Manual therapy, physical therapy, or continued care by a general practitioner for patients with neck pain. A randomized, controlled trial. *Ann Intern Med*. 2002 May 21;136(10):713-22.

8 Gross AR, Hoving JL, Haines TA, Goldsmith CH, Kay T, Aker P, Bronfort G, Cervical overview group. Manipulation and Mobilisation for Mechanical Neck Disorders. *Cochrane Database Syst Rev*. 2004;1:CD004249.

9 Koes, B, Bouter, L, et al. Randomised clinical trial of manipulative therapy and physiotherapy for persistent back and neck complaints: results of one year follow up. *BMJ* 1992;304:601-5.

10 Koes BW, Bouter LM van Mameren H, et al. A randomized clinical trial of manual therapy and physiotherapy for persistent neck and back complaints: sub-group analysis and relationship between outcome measures. *J Manipulative Physio Ther* 1993;16:211-9.

11 Cassidy JD, Lopes AA, Yong-Hing K. The immediate effect of manipulation versus mobilization on pain and range of motion in the cervical spine: A randomized controlled trial. *J Manipulative Physio Ther* 1992;15:570-5.

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

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

14 Texas Labor Code 408.021

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