



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: Allied Multicare Centers 415 Lake Air Drive Waco, Texas 76710	MDR Tracking No.: M5-06-0966-01
	Claim No.:
Respondent's Name and Address: Box 46	Injured Employee's Name:
	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: "This request for retrospective necessity dispute resolution by an Independent Review Organization of our medical bill(s) pursuant to 133.304, it's being filed with the carrier and the division no later than one (1) year after the date(s) of service in the dispute.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60

POSITION SUMMARY: None 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)
01-24-05 to 03-24-05	98943, 99212, 97112, 97530, 95831 and 97110	<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 disputed medical necessity issues.

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 02-27-06, 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.

On 03-23-06 the Requestor withdrew dates of service 01-25-05 and 02-08-05 as well as 2 units of CPT code 95831 for date of service 03-08-05, therefore, these services will not be a part of the review.

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:

Authorized Signature

03-29-06

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.

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 3/27/06

TDI-WC Case Number:	
MDR Tracking Number:	M5-06-0966-01
Name of Patient:	
Name of URA/Payer:	Allied Multicare Centers
Name of Provider: (ER, Hospital, or Other Facility)	Allied Multicare Centers
Name of Physician: (Treating or Requesting)	Micah Mordecai, DC

March 20, 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

Records reviewed included:

Benefit Contested Case Hearing Decision & Order

X-ray Reports, Coryell Memorial Hospital

Medical Reports, Gary Becker, MD

MRI Reports, MRI Center of Providence

Operative Reports, Waco Orthopedic clinic, Fish Pond Surgery Center

Chiropractic notes, Michael Mattage, DC

Physical Therapy notes, Coryell County Memorial Hospital

Chiropractic Reports, Allied Multicare Center

Behavioral Medicine Reports, Injury 1 Treatment Center

Impairment Evaluation, David Savage, MD

Chiropractic Notes & Reports, Micah Mordecai, DC

IME Reports, William Blair, MD

RME Reports & Impairment Rating, David Savage, MD

Available information suggests that this patient reports experiencing an occupational injury on ___ involving her knees. X-ray performed 03/23/04 reveal degenerative changes but no fracture, dislocation or bone abnormally. MRI of the right knee performed 04/04/04 shows posterior horn meniscal tear with a small amount of effusion and a tiny popliteal cyst. The patient was seen for orthopedic evaluation by Dr. Gary Becker. The patient underwent left knee arthroscopic meniscectomy on 05/13/04 and right knee meniscectomy on 12/22/04 with Dr. Becker and was released to light duty on 02/02/05. The patient began seeing a chiropractor, Dr. Mordecai, for knee pain on 11/01/04. Dr. Mordecai began performing both active and passive therapy including manipulation on 12/21/04 and continued these services through 03/24/05. Chiropractic notes suggest that the patient is provided multiple sessions of neuromuscular reeducation and

both therapeutic exercise and therapeutic activities. No therapy notes are provided suggesting exactly how these services are performed, what specific deficits are identified and what goals or parameters are set to address these deficits. Dynatron strength and motion tests do appear to be performed, however no specific clinical correlation appears made with these findings, treatment plan or desired effect of treatment. Chiropractic plan on daily reporting from 01/25/05 to 03/24/05 simply indicates that the patient undergoes chiropractic adjustments and therapeutic applications at 3x per week with direct patient contact but no therapist, supervisor or instructor identified. Daily treatment notes do identify Allied Multicare Centers and Dr. Micah Mordecai but no signature or initials of therapist are affixed to these documents.

REQUESTED SERVICE(S)

Determine medical necessity for office visits (99212), chiropractic manipulation (98943), neuromuscular reeducation (97112), therapeutic activities (97530), therapeutic exercises (97110), and manual muscle testing (95831) for period in dispute 01/24/05 through 03/24/05.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

Medical necessity for these ongoing treatments and services (01/24/05 to 03/24/05) **are not supported by documentation provided.** The chiropractic office visits (99212) and CMT services (98943) are mutually exclusive services. Both of these services contain evaluation and management components and it is considered inappropriate for these services to be billed together on the same date of service. CMT chiropractic manipulation services (98943) applied for extremity treatment/management has not been demonstrated to be clinically appropriate for a working diagnosis of "meniscal tear." In fact, there is considerable chiropractic and orthopedic literature suggesting that manual manipulation of a knee with meniscal tear is clinically contraindicated. Neuromuscular reeducation (97112) is a very specific functional activity that involves active and passive components of balance, kinesthetic sense and proprioception. Chiropractor does not provide specific DOP suggesting how this application is administered and for what specific purpose relative to working diagnosis. In addition, both (97530 & 97110) therapeutic activities and exercises

requires some level of therapist's documentation, flowcharting, goals assessment or other specific DOP suggesting exactly how this is performed, where this is performed and for what purpose relative to working diagnosis and established treatment goals. No minimal documentation of this nature is provided for review other than limited, unsigned daily treatment notes from Allied Multicare Centers. As Dynatron strength and motion testing (95831) contained no specific clinical correlation, and data did not appear to influence treatment modifications, no specific medical necessity for this service appears appropriately documented.

References:

1. Philadelphia Panel Evidence-Based Clinical Practice Guidelines on Selected Rehabilitation Physical Therapy, Volume 81, Number 10, October 2001.
2. Lewit K. *Manipulative Therapy in Rehabilitation of the Motor System*. London: Butterworths, 1985.
3. Bigos S., et. al., AHCPR, Clinical Practice Guideline, Publication No. 95-0643, Public Health Service, December 1994.
4. Harris GR, Susman JL: "Managing musculoskeletal complaints with rehabilitation therapy" Journal of Family Practice, Dec, 2002.
5. Critchley IJ, Bracey DJ. "Manipulation for knee injuries", *Injury*. 1985 Jan;16(4):281-3. PMID: 3967919
6. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Mercy Center Consensus Conference, Aspen Publishers, 1993.
7. Kim D, Gill TJ, Millett PJ. Arthroscopic management of the arthrofibrotic knee. *Arthroscopy* 2004, Jul;20 Suppl 2:187-94.
8. Suter E., et al. "Appropriateness of manipulation for the pre and post surgical knee" *JMPT* Feb. 2000.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent

documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials.

No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned individual. These opinions rendered do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.

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