



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: James D. Tanner, D.C. 5350 S. Staples Ste 210 Corpus Christi, TX 78411	MDR Tracking No.: M5-06-1083-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: TX Mutual Insurance Company, Box 54	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, "I believe that the treatments that we performed were medically necessary and helped in the rehabilitation of the injured worker and allowed him to return to work with only mild restrictions."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC-60 response. Position Summary states, "Texas Mutual requests that the request for dispute resolution filed be conducted under the provisions of the APA set out above."

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)
3-7-05 – 4-27-05	CPT code 98940 (\$31.36 X 15 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$470.40
3-7-05 – 4-27-05	CPT codes G0283, 97012, 97112, 97124, 97110, 99213	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
	Total		\$470.40

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 requestor submitted a revised Table of Disputed Services on March 15, 2006. This Table was used for this review.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.202

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 \$470.40. 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 by:

Donna Auby, Medical Dispute Officer

5-3-06

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.

April 21, 2006

ATTN: Program Administrator
Texas Department of Insurance/Workers Compensation Division
7551 Metro Center Drive, Suite 100
Austin, TX 78744
Delivered by fax: 512.804.4868

Notice of Determination

MDR TRACKING NUMBER: M5-06-1083-01
RE: Independent review for _____

The independent review for the patient named above has been completed.

- Parker Healthcare Management received notification of independent review on 3.15.06.
- Faxed request for provider records made on 3.17.06.
- Order for production of documents was issued 3.29.06.
- The case was assigned to a reviewer on 4.10.06.
- The reviewer rendered a determination on 4.20.06.
- The Notice of Determination was sent on 4.21.06.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of G0283-E-Stim, 97012-mechanical traction, 97112- neuro re-education, 97124- massage, 97110- therapeutic exercises, 98940-chiro manipulation and 99213-office visits
Dates in Dispute: 3.7.05-4.27.05

Determination

PHMO, Inc. has performed an independent review of the proposed care to determine if the adverse determination was appropriate. After review of all medical records received from both parties involved, the PHMO, Inc. physician reviewer has determined to **overturn the denial** on all of the disputed procedure code: 98940-chiro manipulation that occurred between 3.7.05-4.27.05.

The PHMO, Inc. physician reviewer has also determined to **uphold the denial** on all of the other disputed procedures: G0283-E-Stim, 97012-mechanical traction, 97112- neuro re-education, 97124- massage, 97110- therapeutic exercises and 99213-office visits that occurred between 3.7.05-4.27.05.

Summary of Clinical History

Patient is a 35-year-old male oil rig driller who, on ____, was repeatedly lifting heaving iron pieces when he developed lower back and left inguinal pain. He reported the incident, but continued to work over the next couple of days. When the pain worsened and he developed a bulge in the left inguinal area, he presented himself to the medical doctor who had previously performed a right hernia repair on him. He eventually experienced a good subsequent to his hernial repair, but his lower back pain continued.

He then sought care with doctor of chiropractic who first tried conservative treatments, but when those failed, he underwent a 2-level disc decompression on 11.16.04. He then participated in a post-operative therapy program that included chiropractic manipulative treatments, physical therapy and rehabilitation.

Clinical Rationale

In this case, the medical records submitted adequately documented that a compensable injury to the patients lower back occurred. Therefore, the medical necessity for the performance of periodic spinal manipulations (98940) was supported.

However, with regard to the neuromuscular reeducation 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 Bulletin 1, “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.

In addition, in terms of the mechanical traction (97102), the patient had already undergone a two-level disc decompression. Therefore, the continued need for this physical therapy modality was no longer supported as medically necessary within the documentation submitted.

With regard to the therapeutic exercises (97110), nothing in either the medical records or the diagnosis supported the medical necessity of continued supervised training as opposed to home exercises. 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. On the most basic level, the provider failed to establish why the therapeutic exercises were still necessary 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.”²

In terms of the electrical stimulation, unattended (G0283), the ACOEM Guidelines 3 state that passive modalities such as massage, diathermy, TENS units, have no proven efficacy in treating acute low back symptoms. The NASS Guidelines⁴ state that passive interventions are indicated during the first 8 weeks only “if clinically indicated and not previously unsuccessful.” Therefore, since the surgery was performed on 11.16.04, and the first date in dispute was 3.7.05 performing this service, it was not supported as being medically necessary.

With regard to the massage treatments (97124), nothing in either the medical records or the diagnosis supported the performance of this service (i.e., muscular spasticity, spasm, etc.) Therefore, its medical necessity was unsupported.

And finally, these individual points notwithstanding, a designated doctor examination was performed on this claimant on 2.25.05, 2 weeks before these dates of service in dispute. By so declaring this patient at MMI, this doctor – who carries presumptive weight – actually reviewed the medical records and examined this patient. And, at the conclusion, he determined the claimant to be at MMI with a 5% whole-person impairment. In making this determination, it was his position that there was little or no probability that additional treatment would result in additional improvement. Therefore, the treatments rendered after that point were deemed not medically necessary.

Clinical Criteria, Utilization Guidelines or other material referenced

References used in this review are noted as footnotes on the bottom of pages 2-3.

The reviewer for this case is a doctor of chiropractic peer matched with the provider that rendered the care in dispute. The reviewer is engaged in the practice of chiropractic on a full-time basis.

The review was performed in accordance with Texas Insurance Code 21.58C and the rules of Texas Department of Insurance /Division of Workers' Compensation. In accordance with the act and the rules, the review is listed on the DWC's list of approved providers or has a temporary exemption. The review includes the determination and the clinical rationale to support the determination. Specific utilization review criteria or other treatment guidelines used in this review are referenced.

The reviewer signed a certification attesting that no known conflicts-of-interest exist between the reviewer and the treating and/or referring 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. The reviewer also attests that the review was performed without any bias for or against the patient, carrier, or other parties associated with this case.

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

2 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.

3 ACOEM *Occupational Medicine Practice Guidelines: Evaluation and Management of Common Health Problems and Functional Recovery in Workers, 2nd Edition*, p. 299.

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

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. The address for the Chief Clerk of Proceedings would be: P.O. Box 17787, Austin, Texas, 78744.

I hereby verify that a copy of this Findings and Decision was faxed to Texas Department of Insurance /Division of Workers Compensation applicable to Commission Rule 102.5 this 21st day of April, 2006. The Division of Workers Compensation will forward the determination to all parties involved in the case including the requestor, respondent and the injured worker.

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.