



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	
Requestors Name and Address: Southeast Health Services P. O. Box 453062 Garland, Texas 75045	MDR Tracking No.: M5-06-1745-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: American Zurich Insurance Company, Box 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary (Table of Disputed Services) states, "Denied per peer review."
Principle Documentation:

1. DWC-60/Table of Disputed Service
2. CMS-1500's
3. EOB's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary states, "...The carrier disputes that the provider has shown that the treatment underlying the charges was medically reasonable and necessary. Further, the carrier challenges whether the charges are consistent with applicable fee guidelines. The carrier asserts that it has paid according to applicable fee guidelines..."
Principle Documentation:

1. DWC-60/Table of Disputed Service

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)
6-24-05	97750-FC (10 units @ \$38.65)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$386.50
6-24-05	99080-73	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$15.00
6-2-05 – 7-9-05	99211, 97110-59, 97032, 97016, 93799, 99080-73 (except 6-24-05)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
Grand Total			\$401.50

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 amount due the Requestor for the items denied for medical necessity is \$401.50.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011 and 413.031
28 Texas Administrative Code Sec. 134.1, 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 \$401.50. The Division hereby **ORDERS** the Respondent 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:

_____	Medical Dispute Officer	9-8-06
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.

July 25, 2006

TX DEPT OF INS DIV OF WC
AUSTIN, TX 78744-1609

CLAIMANT: ___

EMPLOYEE: ___

POLICY: M5-06-1745-01

CLIENT TRACKING NUMBER: M5-06-1745-01 5278

Medical Review Institute of America (MRIOA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Department of Insurance Division of Workers Compensation has assigned the above mentioned case to MRIOA for independent review in accordance with DWC Rule 133 which provides for medical dispute resolution by an IRO.

MRIOA has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the DWC approved doctor list (ADL). The reviewing provider has no known conflicts of interest existing between that 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.

Records Received:

Records Received from State (DWC):

Notification of IRO Assignment dated 7/6/06 - 10 pages

Records Received from Respondent (American Zurich Insurance Company):

Letter to DWC from Flahive, Ogden & Latson dated 6/27/06 - 2 pages

Letter to MRIOA from Flahive, Ogden & Latson dated 7/13/06 - 2 pages

Peer Review dated 5/24/05 - 4 pages

Peer Review dated 12/1/05 - 4 pages

Addendum Peer Review dated 12/13/06 - 3 pages

Records Received from Requestor (Southeast Health Services):

Initial Consultation Report, Charles E. Willis, II, MD dated 2/1/05 (page 1 of ?) - 1 page

Medical records of W. Garner Newton, MD dated 2/16/05, 3/28/05, 5/11/05 - 5 pages

Texas Workers' Compensation Work Status Report, Bryan L. Weddle, DC dated 2/7/05, 3/4/05, 3/18/05, 4/27/05, 5/16/05, ?/27/05, 6/17/05, 6/24/05 - 8 pages

MRI knee without contrast (left) dated 2/4/05 - 2 pages

Initial FCE, Dr. Weddle dated 6/24/05 - 10 pages

Treatment Plan, Dr. Weddle, dated 2/11/05-3/2/05, 3/10/05-4/1/05, 3/30/05-4/29/05 - 3 pages

Treatment Plan, Dr. Weddle, dated 2/10/05, 3/4/05, 3/29/05, 5/25/05, undated, 7/2/05, undated - 7 pages

Office notes, Dr. Weddle, dated 1/27/05-8/25/05 - 121 pages

Summary of Treatment/Case History:

The patient is a 51-year-old male who, on ____, was stepping down off a dock when his foot slipped, twisted his left knee and fell, causing sudden medial left knee pain. He was seen the following day at the Concentra Medical Center, was diagnosed with a medical collateral ligament sprain, dispensed a prescription for oral steroids, and returned to work with restrictions. On 1/27/05, he presented himself to the treating doctor of chiropractic who placed him on temporary total disability, and began a trial of conservative chiropractic care, including physical therapy and rehabilitation.

Despite the conservative trial, the claimant underwent arthroscopic repair to his left knee on 3/24/05, specifically consisting of ACL reconstruction, partial lateral meniscectomy of the posterior horn of the lateral meniscus, abrasion chondroplasty of the patellofemoral joint and medial femoral condyle, and chondral picking of the medial femoral condyle, followed by post-operative physical therapy and rehabilitation.

Questions for Review:

Were the level I established patient office visits (#99211), the therapeutic exercises (#97110), the attended electrical simulation therapies (#97032), the vasopneumatic devices (#97016), the unlisted procedures (#93799), the DWC report (#99080-73), and the function capacity evaluation (#97750-FC) from 6/2/05 through 7/9/05 medically necessary to treat this patient's injury?

Explanation of Findings:

Were the level I established patient office visits (#99211), the therapeutic exercises (#97110), the attended electrical simulation therapies (#97032), the vasopneumatic devices (#97016), the unlisted procedures (#93799), the DWC report (#99080-73), and the function capacity evaluation (#97750-FC) from 6/2/05 through 7/9/05 medically necessary to treat this patient's injury?

The DWC report (#99080-73) and the functional capacity evaluation (#97750-FC) performed on 6/24/05 were medically necessary; all remaining services and procedures were not medically necessary.

In this case, it was prudent for the treating doctor to complete and submit periodic required reports to the carrier and to DWC, so these services were supported as medically necessary. Also, according to the medical records, the claimant was due by 6/24/05 for a follow-up functional capacity evaluation to determine work status at the completion of his post-operative therapy and rehabilitation, so this service was supported as medically necessary.

In terms of the other services, the treating doctor utilized a "Matrix System" device that he further described as a "Non-invasive Nerve Block and a Vasopneumatic application to decrease localized and radicular pain as well as edema around the injured tissue." However, upon review of the examination and the daily treatment notes, there was no evidence for the findings of edema and/or lymphedema to support the medical necessity of this procedure. In fact, not a single reference in the treating doctor's daily notes during the time frame in dispute recorded a finding of edema or swelling in the patient. According to a Medicare Policy Statement (1), "The use of vasopneumatic devices may be considered reasonable and necessary for the application of pressure to an extremity for the purpose of reducing edema. Specific indications for the use of vasopneumatic devices include the reduction of edema after acute injury and lymphedema of an extremity." Since neither the examination nor the daily treatment notes made specific reference to the presence of lymphedema, the treatment in question was not medically necessary.

Insofar as the level I office visits were concerned, and according to CPT (2), nothing in either the medical records or the diagnosis in this case supported the medical necessity of performing an Evaluation and Management (E/M) service on each and every patient visit, particularly not while in the middle of an already-determined treatment plan, and not while under the supervision and management of multiple other health care providers. Such practices are not supported as medically necessary.

With respect to the attended electrical stimulation, nothing in the medical records indicated why it was still necessary—particularly 3 months post-surgically—to perform this particular modality. In the absence of this essential supportive documentation, the medical necessity was unsupported.

Finally, in terms of the therapeutic exercises, by the time of the dates in dispute in this case, the patient had already participated in 18 months of supervised, one-on-one exercises. And, nothing in the medical records submitted provided sound clinical rationale for why it was still necessary at that point that the claimant continue with supervised, one-on-one exercises, versus being safely transitioned into a home exercise program. Because of that, and the fact that current medical literature states, "...there is no strong

evidence for the effectiveness of supervised training as compared to home exercises,” (3) continued supervised therapeutic exercises after 6/2/06 was not supported as medically necessary.

Conclusion/Decision to Certify:

The DWC report (#99080-73) and the function capacity evaluation (#97750-FC) performed on 6/24/05 were medically necessary.

Conclusion/Decision to Not Certify:

The level I established patient office visits (#99211), the therapeutic exercises (#97110), the attended electrical simulation therapies (#97032), the vasopneumatic devices (#97016), and the unlisted procedures (#93799) from 6/2/05 through 7/9/05 were not medically necessary.

References Used in Support of Decision:

- 1) Medicare Medical Policy Bulletin Y-1S: Physical Therapy and Rehabilitation Services
- 2) *CPT 2004: Physician's Current Procedural Terminology, Fourth Edition, Revised.* (American Medical Association, Chicago, IL 1999),
- 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 cochrane collaboration. *Spine.* 2003 Feb 1;28(3):209-18.

This review was provided by a chiropractor who is licensed in Texas, certified by the National Board of Chiropractic Examiners, is a member of the American Chiropractic Association and has several years of licensing board experience. This reviewer has given numerous presentations with their field of specialty. This reviewer has been in continuous active practice for over twenty years.

MRloA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the treating provider, payor and/or URA, and the DWC.

It is the policy of Medical Review Institute of America to keep the names of its reviewing physicians confidential. Accordingly, the identity of the reviewing physician will only be released as required by state or federal regulations. If release of the review to a third party, including an insured and/or provider, is necessary, all applicable state and federal regulations must be followed.

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The written opinions provided by MRloA represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to MRloA for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Medical Review Institute of America assumes no liability for the opinions of its contracted physicians and/or clinician advisors. The health plan, organization or other party authorizing this case review agrees to hold MRloA harmless for any and all claims which may arise as a result of this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

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Case Analyst: Lori B ext 569