



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: Nestor Martinez, D.C. 6660 Airline Drive Houston, Texas 77076	MDR Tracking No.: M5-06-1788-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Rep Box # 42	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: ... "Our facility feels like our services were medically necessary, due to the fact that all of the doctors listed above including her treating physician has recommended that this patient continue with physical therapy to help improve the strength in her left arm. We also tried to get the patient the care that she needed. However, due to the workers' compensation system we could NOT do so."

Principle Documentation:

1. DWC-60/Table of Disputed Services
2. CMS 1500's
3. Explanation of Benefits

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: ... "Accordingly, additional payment was made for the first 18 sessions, as noted on the attached table of disputed services and explanations of benefit. The remainder of the services was considered to be medically unnecessary with and without peer review..."

Principle Documentation: Response to DWC-60

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
06-15-05 to 08-31-05	97110, 97140, and 97112	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
07-07-05 to 08-31-05	99212	<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, Medical Dispute Resolution has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained fee issues that were not addressed by the IRO and will be reviewed by Medical Dispute Resolution.

On 06-21-06, Medical Dispute Resolution 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 99212 billed by the Requestor on dates of service 06-15-05, 06-17-05, 06-20-05, 06-22-05, 06-24-05, 06-27-05, 06-30-05, 07-01-05 and 07-05-05 was denied by the Respondent with denial code "G" (unbundling). Per Rule 134.202 CPT code 99212 is not global to other CPT codes billed on the dates of service. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$444.69 (\$49.41 X 9 DOS)**.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.1 and 134.202, 134.202(c)(1)
Texas Labor Code, Sec. 413.031 and 413.011 (a-d)

PART VII: DIVISION FINDINGS 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 \$444.69. In addition, 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 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.

Order by:

08-16-06

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.

NOTICE OF INDEPENDENT REVIEW DECISION

July 21, 2006

Amended Letter: August 3, 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 #: M5-06-1788-01
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 patient sustained a work related injury on _____ when she fell back and landed on her shoulder and fractured her humerus. She underwent chiropractic treatments and physical therapy.

Requested Service(s)

(99212) Office visits, (97110) Therapeutic exercises, (97140) Manual therapy technique, and (97112) Neuromuscular provided from 06/15/05 to 08/31/05

Decision

It is determined that the (99212) Office visits, (97110) Therapeutic exercises, (97140) Manual therapy technique, and (97112) Neuromuscular provided from 06/15/05 to 08/31/05 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 expectations include: (A) Home care programs should be initiated near the beginning of care, include ongoing assessments of compliance and result in fading treatment frequency. (B) 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. (C) Supporting documentation for additional treatment must be furnished when exceptional factors or extenuating circumstances are present. (D) 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 the 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.

The medical record documentation fails to substantiate that the aforementioned services fulfilled the statutory requirements¹ 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, there was significant improvement from the date of the examinations performed on 06/06/05 and 07/27/05; and no improvement between the examinations performed on 07/27/06 and 10/14/05.

Specifically in regard to the office visits and based on CPT², there is no support for the medical necessity for the E/M service (99212) on most every visit during an established treatment plan.

¹ Texas Labor Code 408.021

² CPT 2004: Physician's Current Procedural terminology, Fourth Edition, Revised. (American Medical Association, Chicago, IL 1999)

Specifically in 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 Bulletin³, “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.

Therapeutic exercises (97110) may be performed in a clinic one-on-one, in a clinic in a 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.”⁴

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 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.

Sincerely,

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

3 HGSA Medicare Medical Policy Bulletin, Physical Therapy Rehabilitation Services, original policy effective date 04/01/1993 (Y-1B)
4 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