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 Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor=s Name and Address:	MDR Tracking No.: M5-06-1880-01
Nestor Martinez, D.C. 6660 Airline Drive Houston, Texas 77076	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
Rep Box # 45	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: Per the Table of Disputed Services "*Note: This dispute should be docketed as an M4 (fee dispute) b/c TDI has not adopted the CMS Guidelines."

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: "Based on the Medicare guidelines the Office will maintain denial as exceeding the standard medical practice without clinical justification."

Principle Documentation:

1. 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)
07-07-05 to 10-31-05	99211, 99212, 97140 and 97112	☐ Yes ☒ No	$0.00
	TOTAL DUE		$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.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

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

PART VII: DIVISION FINDINGS AND 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 reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

		09-22-06
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.

Medical Review Institute of America, Inc.
America's External Review Network

MRI

August 21, 2006

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

CLAIMANT: ___
EMPLOYEE: ___
POLICY: M5-06-1880-01
CLIENT TRACKING NUMBER: M5-06-1880-01

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 THE STATE:
Notification of IRO Assignment, Table of Disputed Services, Carrier EOBs, 24 pages

RECORDS RECEIVED FROM THE REQUESTOR:
Office notes, Dr. Varon, 6/6/05, 7/7/05, 9/15/05, 3 page
Physical Medicine Referral, 6/6/05, 1 page
Post surgical evaluation dated 6/8/05, 3 pages
Office notes, Dr. McMillan, 6/28/05, 8/2/05, 10/6/05, 11/15/05, 8 pages
PT evaluation, 8/15/05, 2 pages

Summary of Treatment/Case History:
The patient is a male who, on ___, sustained an injury to his left wrist. He was eventually diagnosed with De Quervain's disease, and subsequently underwent De Quervain's release on 3/10/05, followed by post-surgical physical therapy and rehabilitation. Although this seemed to adequately address his De Quervain's symptoms, he then developed a fairly large and symptomatic mass in the left wrist that was diagnosed as a synovial cyst that, in turn, required a separate excision and biopsy.

Questions for Review:
Dates of Service 7/7/05 through 10/31/05
1. Services for review: Office visits (#99211/#99212), manual therapy technique (#97140) and neuromuscular re-education (#97112). Please review for medical necessity.

Explanation of Findings:
1. Services for review: Office visits (#99211/#99212), manual therapy technique (#97140) and neuromuscular re-education (#97112). Please review for medical necessity.

No. 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) 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 this case, there was no documentation of objective or functional improvement in this patient's condition, and no evidence of a change of treatment plan that would have justified additional treatment. In fact, the medical records submitted demonstrated a worsening of the claimant's condition from the 6/8/05 examination date compared to the 8/15/05 evaluation, particularly in terms of the range of motion. As such, the joint mobilization (#97140) did not meet the statutory requirements for medical necessity since the patient did not obtain relief and promotion of recovery was also not accomplished.

In regard to the office visits, according to the requirements under CPT, nothing in either the diagnosis or the medical records supported the medical necessity of performing an evaluation and management service (E/M) on each and every date of service, particularly not during an already-established treatment plan, and while under the care and orders of other physicians.

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 Bulletin, "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.

Conclusion/Decision to Not Certify:
Medical necessity has not been established for the office visits (#99211/#99212), manual therapy technique (#97140) and neuromuscular re-education (#97112).

References Used in Support of Decision:
Texas Labor Code 408.021
CPT 2004: Physician's Current Procedural Terminology, Fourth Edition, Revised. (American Medical Association, Chicago, IL 1999),
HGSA Medicare Medical Policy Bulletin, Physical Therapy Rehabilitation Services, original policy effective date 04/01/1993 (Y-1B)

This review was provided by a chiropractor licensed in Texas, certified by the National Board of Chiropractic Examiners, and who is a member of the American Chiropractic Association and has several years of licensing board experience. This reviewer has written numerous publications and given several
pr
tw

MRIoA 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.

Medical Review Institute of America retains qualified independent physician reviewers and clinical advisors who perform peer case reviews as requested by MRIoA clients. These physician reviewers and clinical advisors are independent contractors who are credentialed in accordance with their particular specialties, the standards of the American Accreditation Health Care Commission (URAC), and/or other state and federal regulatory requirements.

The written opinions provided by MRIoA 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 MRIoA 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 MRIoA 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.

1247497.1
Case Analyst: Stacie S ext 577