



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: Dr. Patrick R.E. Davis 101 W. Allen Avenue Fort Worth, Texas 76110	MDR Tracking No.: M5-06-1972-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Rep Box # 03	Date of Injury:
	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 "Documentation supports medical necessity."

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: Per the Table of Disputed Services "It is the carrier's contention that treatment for dates of service 08/26/05 through 10/21/05 was not medically necessary. We will await IRO assignment."

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)
08-26-05	98940	<input checked="" type="checkbox"/> <input type="checkbox"/> Yes <input type="checkbox"/> No	\$32.55
08-26-05, 09-08-05, 09-16-05 and 09-20-05	97140-59 (1 unit @ \$33.04 X 4 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$132.16
09-06-05, 09-09-05, 09-12-05, 09-14-05 and 09-19-05	97140-59 (1 unit @ \$33.04 X 2 units X 5 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$330.40
08-26-05 to 09-20-05	97112-59 (1 unit @ \$36.79 X 9 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$331.11
08-26-05 to 09-20-05	97110 (1 unit @ \$34.93 X 2 units X 9 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$628.74
09-08-05 and 09-16-05	97035 (1 unit @ \$15.11 X 2 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$30.22
08-26-05 to 09-20-05	97110 (1 unit @ \$34.93 X 4 units X 9 DOS)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
08-26-05 to 10-21-05	97032 and E0745	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
09-26-05 to 10-21-05	97140, 97112, 97530, 98940 and 98943	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
09-20-05 and 10-12-05	A4556 (*see note below)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$0.00
	*Note: Although the IRO reviewer found HCPCS code A4556 to be medically necessary this is a bundled code per Rule 134.202, therefore, no reimbursement is recommended.		
	TOTAL DUE		\$1,485.18

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.

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 08-17-2006, 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 97140 (2 units) billed for date of service 09-23-05 was denied by the Respondent with denial code "62" (payment denied/reduced for absence of, or exceeded, pre-certification/authorization). Per Rule 134.600 pre-certification/authorization is not required. Reimbursement is recommended in the amount of **\$66.08 (1 unit @ \$33.04 x 2 units)**.

CPT code 97112 (1 unit) billed for date of service 09-23-05 was denied by the Respondent with denial code "62" (payment denied/reduced for absence of, or exceeded, pre-certification/authorization). Per Rule 134.600 pre-certification/authorization is not required. Reimbursement is recommended in the amount of **\$36.79**.

CPT code 97110 (6 units) billed for date of service 09-23-05 was denied by the Respondent with denial code "62" (payment denied/reduced for absence of, or exceeded, pre-certification/authorization). Per Rule 134.600 pre-certification/authorization is not required. Reimbursement is recommended in the amount of **\$209.58 (1 unit @ \$34.93 X 6 units)**.

CPT code 97112 billed for date of service 09-26-05 was denied by the Respondent with denial codes "29" (the time limit for filing has expired), "309" (charge exceeds Fee Schedule Allowance), "42" (charges exceed our fee schedule or maximum allowable amount), "937" (services not timely filed by the provider) and "W4" (no additional reimbursement allowed after review of appeal/reconsideration). The Requestor did not submit a copy of the original CMS 1500 for review, nor did the Requestor submit proof the service was billed before the 95 day filing deadline per Section 408.027(a) which requires health care providers to submit medical bills to the insurance carrier no later than 95 days after the date the services are provided to the injured employee. Additionally, this language states that "failure to timely submit a medical bill constitutes a forfeiture of the provider's right to reimbursement for that bill." Therefore, CPT code 97112 for this date of service will not be reviewed.

CPT code 97035 billed for date of service 09-26-05 was denied by the Respondent with denial codes "29" (the time limit for filing has expired), "309" (charge exceeds Fee Schedule Allowance), "42" (charges exceed our fee schedule or maximum allowable amount), "937" (services not timely filed by the provider) and "W4" (no additional reimbursement allowed after review of appeal/reconsideration). The Requestor did not submit a copy of the original CMS 1500 for review, nor did the Requestor submit proof the service was billed before the 95 day filing deadline per Section 408.027(a) which requires health care providers to submit medical bills to the insurance carrier no later than 95 days after the date the services are provided to the injured employee. Additionally, this language states that "failure to timely submit a medical bill constitutes a forfeiture of the provider's right to reimbursement for that bill." Therefore, CPT code 97035 for this date of service will not be reviewed.

CPT code 97530 billed for date of service 09-26-05 was denied by the Respondent with denial codes "29" (the time limit for filing has expired), "309" (charge exceeds Fee Schedule Allowance), "42" (charges exceed our fee schedule or maximum allowable amount), "937" (services not timely filed by the provider) and "W4" (no additional reimbursement allowed after review of appeal/reconsideration). The Requestor did not submit a copy of the original CMS 1500 for review, nor did the Requestor submit proof the service was billed before the 95 day filing deadline per Section 408.027(a) which requires health care providers to submit medical bills to the insurance carrier no later than 95 days after the date the services are provided to the injured employee. Additionally, this language states that "failure to timely submit a medical bill constitutes a forfeiture of the provider's right to reimbursement for that bill." Therefore, CPT code 97530 for this date of service will not be reviewed.

CPT code 97035 billed for dates of service 12-20-05 and 12-21-05 was denied by the Respondent with denial codes "29" (the time limit for filing has expired), "309" (charge exceeds Fee Schedule Allowance) and "42" (charges exceed our fee schedule or maximum allowable amount). The Requestor submitted proof of the original billing which was within the 95 day filing deadline per Section 408.027(a) which requires health care providers to submit medical bills to the insurance carrier no later than 95 days after the date the services are provided to the injured employee. However, per Rule 134.600 this service required preauthorization for services billed on or after 12-01-05. The Requestor did not submit proof of preauthorization being obtained prior to the service being provided. No reimbursement recommended.

CPT code 98940 (3 units total) billed for dates of service 12-20-05, 12-21-05 and 12-22-05 was denied by the Respondent with denial codes "29" (the time limit for filing has expired), "309" (charge exceeds Fee Schedule Allowance) and "42" (charges exceed our fee schedule or maximum allowable amount). The Requestor submitted proof of the original billing which was within the 95 day filing deadline per Section 408.027(a) which requires health care providers to submit medical bills to the insurance carrier no later than 95 days after the date the services are provided to the injured employee. Reimbursement is recommended per Rule 134.202 in the amount of **\$97.65 (\$32.55 X 3 units)**.

CPT codes 97140, 97112 and 97110 billed for dates of service 12-20-05, 12-21-05 and 12-22-05 were denied by the Respondent with denial codes "29" (the time limit for filing has expired), "309" (charge exceeds Fee Schedule Allowance) and "42" (charges exceed our fee schedule or maximum allowable amount).). The Requestor submitted proof of the original billing which was within the 95 day filing deadline per Section 408.027(a) which requires health care providers to submit medical bills to the insurance carrier no later than 95 days after the date the services are provided to the injured employee. However, per Rule 134.600 this service required preauthorization for services billed on or after 12-01-05. The Requestor did not submit proof of preauthorization being obtained prior to the services being provided. No reimbursement recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.1, 134.202 134.600
Texas Labor Code, Sec. 413.031, 413.011 (a-d) and 408.027(a)

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 \$1,895.28. 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:

11-08-06

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.

Clear Resolutions Inc.
An Independent Review Organization
3616 Far West Blvd. Suite 337-117
Austin, TX 7831

Amended October 27, 2006
Amended October 13, 2006
October 4, 2006

TDI-DWC Medical Dispute Resolution
Fax: (512) 804-4868

Delivered via Fax

Patient / Injured Employee _____
TDI-DWC _____
MDR Tracking #: M5-06-1972-01
IRO #: 5327

Clear Resolutions, Inc. has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI-Division of Worker's Compensation (DWC) has assigned this case to Clear Resolutions for independent review in accordance with DWC Rule 133.308 which allows for medical dispute resolution by an IRO.

Clear Resolutions 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.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Provider board certified and specialized in Chiropractic Care. The Reviewer is on the DWC Approved Doctor List (ADL). The Clear Resolutions Panel Member/Reviewer is a health care professional who has signed a certification statement stating that no known conflicts of interest exist between the Reviewer 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 carriers health care providers who reviewed the case for decision before referral to IRO America for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

RECORDS REVIEWED

Notification of IRO assignment, information provided by The Requestor, Respondent, and Treating Doctor(s), including but not limited to:

1. Medical Dispute Resolution Request.
2. Table of Disputed Services, 8-26-05 through 12-20-05.
3. Explanation of Benefits, 8-31-05 through 9-23-05.
4. First Report of Injury, 7-28-05.
5. Chiropractic examinations, 7-28-05, 8-26-05, 9-23-05, and 10-21-05.
6. Medical reports from Ved Aggarwal, MD, 8-16-05, 9-20-05, and 10-24-05.
7. Chiropractic reports, 8-31-05, 12-16-05, 1-20-06, 5-2-06, and 6-16-06.
8. EMG/NSC Report from Frank Morrison, MD, 9-21-05.
9. Cervical MRI report, 10-6-05.
10. Left shoulder MRI report, 10-6-05.
11. DD Evaluation from Dr. Lawrence, 10-13-05.
12. Procedure Notes (ESI), 11-22-05, 12-15-05, and 1-19-06.
13. Medical reports from Ved Aggarwal, MD, 12-5-05 and 12-27-05.
14. Medical reports from Joseph Daniels, DO, 3-1-06, 4-4-06, 6-1-06, and 7-12-06.
15. Operative report, 3-28-06.
16. Position Statement from BRM, 8-23-06.
17. Packet of ODQ utilization recommendations and CMS criteria.
18. Chiropractic treatment records and therapeutic procedure reports, 7-28-05 through 10-21-05, approximately 40 sessions.

CLINICAL HISTORY

7-28-05: First report of injury indicates the claimant strained his back while moving a wooden desk.

7-28-05: The claimant was evaluated by Patrick Davis, DC. The claimant was working as a custodian when he sustained a work-related injury on _____. This report indicates the claimant reported experiencing a popping/shearing sensation across the cervical spine and left shoulder region. He was initially seen in the emergency room and prescribed medication. Physical examination demonstrated reduced cervical range of motion, mild dermatomal deprivation/alteration with two-point discrimination, light touch, and pinwheel of the left upper extremity, weakness in the left shoulder and cervical spine with muscle testing. Symptoms were reproduced with cervical compression test, maximal foraminal encroachment test, and cervical distraction test. Left shoulder symptoms were intensified with shoulder apprehension test, impingement test, and supraspinatus press test. Diagnoses included cervical radiculopathy to rule out left HNP, left shoulder sprain to rule out internal derangement, pain, and weakness. Dr. Davis recommended passive and active treatment. His plan specifically indicated that if the patient “continues to experience ongoing symptomatology, dysfunction, and/or suboptimal clinical results after participating in a fair and reasonable course of conservative treatment, appropriate diagnostic studies will be prescribed and provided with additional orthopedic referrals to render further medical recommendations”. 11 sessions of therapy were performed through 8-15-05. Treatment included manual therapy, neuromuscular reeducation, therapeutic procedures, Arctic ice, and extremity manipulation.

8-16-05: The claimant was evaluated by Dr. Aggarwal. The patient reported neck pain, left shoulder pain, and upper back pain. The patient also reported numbness and tingling in the left arm and hand. VRS pain score was 6-8/10. The patient indicated he was unable to work since the injury. The patient indicated he was in treatment 5 times per week but continued to have moderate to severe pain on a daily basis. Cervical extension was 20°, flexion 45°, right lateral flexion 10°, and left lateral flexion 10°. Sensation testing was normal bilaterally. Spurling’s was negative bilaterally. DTR were equal and symmetrical. Motor testing revealed 4/5 strength in the deltoid, biceps, and triceps on the left. Diagnoses included cervical sprain, thoracic sprain, shoulder injury, and muscle spasms. The patient was prescribed Elavil, Flexeril, and Naprosyn.

8-26-05: Re-evaluation with Dr. Davis. This report indicated the patient participated in four weeks of physical medicine and “demonstrated-objective and subjective clinical improvements”. He recommended 12 additional sessions of physical medicine/therapy.

9-20-05: Re-evaluation with Dr. Aggarwal. The patient reported neck and left arm pain. The patient indicated he was 30-40% better with the medications previously prescribed. He indicated he has been able to increase his activity level and tolerate therapy better. VRS was 6-7/10. The patient was not working. Cervical range of motion was reduced. Palpation demonstrated tenderness in the cervical musculature. Spurling’s and compression test were positive. Sensory testing revealed numbness in the C6 dermatome. Left upper extremity strength was graded 4+/5. Dr. Aggarwal recommended a cervical MRI.

9-21-05: EMG/NCV report from Frank Morrison, M.D. The patient reported neck pain and left upper extremity symptoms. Symptoms were characterized as constant, burning, and aggravated with cervical movements, especially cervical extension and left lateral flexion and left rotation. Shoulder flexion was 135° and abduction was 155°. Cervical range of motion was restricted. There was marked pain with palpation. Dr. Morrison was unable to perform Spurling’s. Reflexes were symmetrical. Sensation was diminished to pinprick over the dorsolateral aspect of digits one and two. There were positive findings for a C6 radiculopathy on the left, subacute and moderate to severe. Dr. Morrison recommended an appropriate surgical evaluation if the patient’s progress is slow.

9-23-05: Re-evaluation with Dr. Davis. After participating in 12 additional sessions, Dr. Davis documented the patient “displayed-objective and subjective clinical improvements”. He recommended 12 additional sessions. At this point, the patient participated in approximately 28 sessions of therapy since the work injury. Treatment continued to include manual therapy, neuromuscular reeducation, therapeutic procedures, Arctic ice, and extremity manipulation.

10-6-05: Cervical MRI demonstrated:

1. At C6-7, there is moderate left posterior disc herniation with left lateral recess compromise and moderate proximal left foraminal compromise.
2. At C5-6, there is a small central posterior disc protrusion and probable herniation with mild focal central canal stenosis.
3. Small disc protrusions at C3-4 and C4-5 with borderline mild central canal narrowing.
4. At C3-4, there is mild bilateral foraminal compromise with uncovertebral hypertrophy.

10-6-05: Left shoulder MRI demonstrated:

1. Superior labral tear.

2. Mild biceps tenosynovitis.
3. Mild supraspinatus and possibly subscapularis tendonopathy.
4. Humeral head cortical irregularity and subcortical cyst formation.

10-13-05: DD Evaluation with Richard Lawrence, MD. The patient reported neck pain and radiating left upper extremity symptoms. VAS was 7-8/10. Cervical range of motion was restricted by 25% in all directions. Left shoulder range of motion was restricted by 40%. Supraspinatus was tender with palpation. Impingement signs were positive. There was decreased sensation to pinprick in the left index and middle finger. Grip strength on the left was 1+/4+. DTRs were symmetrical bilaterally. Dr. Lawrence recommended cervical epidural steroid injections and orthopedic surgical consultation for his left shoulder and possibly a neurosurgical consultation for the cervical disc herniations.

10-21-05: Re-valuation with Dr. Davis. He indicated the patient participated in 12 weeks of therapy. Therapy was formally discontinued at the time until further notice. At this point, the patient participated in 40 sessions of therapy under the auspices of Dr. Davis since the work injury. Treatment continued to include manual therapy, neuromuscular reeducation, kinetic procedures, Arctic ice, and extremity manipulation.

10-24-05: Re-evaluation with Dr. Aggarwal. The patient reported neck and left arm pain. He reported ongoing numbness radiating into his hand, thumb, and index finger. VRS was 7.5/10 with medication. The patient was not working. This report indicated the claimant was having referred pain from the cervical spine "unresponsive to therapy, rehab, and the use of medication". Dr. Aggarwal recommended ESI.

11-22-05: A cervical epidural steroid injection was performed at C7-T1.

12-5-05: Re-evaluation with Dr. Aggarwal. The patient was status post epidural steroid injection # 1. The patient reported less pain and increased strength in the left arm. He reported more range of motion in his neck since the injection. VRS was 6.5/10 with medication. Cervical range of motion was restricted. Spurling's was positive. Sensory testing demonstrated numbness in the left upper extremity in the C6 dermatome. Reflexes were symmetrical and equal. The patient reported 30-40% improvement from the first injection; therefore, Dr. Aggarwal recommended a second epidural steroid injection.

12-15-05: Cervical epidural steroid injection # 2 was performed at C7-T1.

12-16-05: Dictated report from Dr. Davis indicated he recommended post-injection therapy.

12-27-06: Re-evaluation with Dr. Aggarwal. The patient reported 50% improvement from the second injection. VRS was 4/10. Cervical range of motion was "almost full". Spurling's was positive. Dr. Aggarwal recommended a third epidural steroid injection.

1-19-06: Cervical epidural steroid injection # 3 was performed at C7-T1.

1-20-06: Dr. Davis recommended post-injection therapy.

2-22-06: The documentation from the American Orthopedic and Neurological clinic indicated the patient reported "hurt!!!" He reported ongoing referred/radiating pain. Pain scale was 10/10. Quality was sharp, stabbing, and throbbing. Symptom frequency was constant. He indicated the only thing that relieved his symptoms was pain relievers. He also reported numbness and tingling.

3-1-06: Evaluation with Joseph Daniels, DO. The patient reported ongoing complaints of pain. Left shoulder examination revealed decreased range of motion both active and passive. Orthopedic testing demonstrated positive Hawkins, Impingement, Apprehension, and Relocation. There was weakness noted in the rotator cuff muscle group. Dr. Daniels indicated the patient failed to respond to conservative care and recommended arthroscopy and probable labral repair.

3-28-06: Left shoulder surgery was performed including arthroscopy, chondroplasty, and synovectomy with repair of the labral SLAP lesion.

4-4-06: Re-evaluation with Dr. Daniels. This was a postoperative evaluation. The patient reported a shoulder pain scale of 3/10. Pain quality was mild to moderate. He prescribes some passive range motion to the left shoulder. Physical examination revealed decreased shoulder range of motion.

5-2-06: Dr. Davis recommended post-surgical therapy for the left shoulder.

6-1-06: Re-evaluation with Dr. Daniels. The patient reported decreased shoulder pain and rated a pain scale of 2-3/10. Pain quality was mild. The patient's range motion was improving. Left shoulder range of motion was considered "good". There was ongoing weakness in the rotator cuff. Apprehension test was negative. Vicodin was prescribed.

6-16-06: Re-examination with Dr. Davis. The patient participated in 18 sessions of postoperative shoulder therapy and Dr. Davis recommended 15 additional sessions of passive and active treatment.

7-12-06: Re-examination with Dr. Daniels. The patient was participating in postoperative therapy with Dr. Davis. Pain scale was 2-3/10. The patient noted some cervical paraspinal musculature pain. The patient was frustrated with his lack of strength. Shoulder range of motion was within normal limits with stiffness and pain. Orthopedic testing of the shoulder was negative. Dr. Daniels recommended additional therapy with Dr. Davis.

DISPUTED SERVICE (S)

Under dispute is the retrospective medical necessity of chiropractic manipulative treatment, manual therapy technique, neuromuscular re-education, electrical stimulation, therapeutic exercises, neuromuscular stimulator, ultrasound, electrodes, and therapeutic activities for the dates 8/26/05 through 12/22/05.

DETERMINATION / DECISION

The Reviewer partially agrees with the determination of the insurance carrier.

The Reviewer agrees with the insurance carrier on the following: The chiropractic manipulation treatment beyond 9-20-05, the manual therapy technique beyond 9-20-05, Ultrasound beyond 9-20-05. The Reviewer also agrees with the insurance carrier that the electrical stimulation, neuromuscular re-education, and neuromuscular stimulator are not medically necessary.

The Reviewer disagrees with the insurance carrier that therapeutic exercises and therapeutic activities before 9/20/05 were medically necessary; and a rental of a home electrical stimulation unit and the pads would be reasonable and necessary. However, more than 2 units of 1-1 guided exercise (97110, 97530, and 97112) per visit would not be reasonable or necessary.

RATIONALE/BASIS FOR THE DECISION

Chiropractic manipulation (98940/98943): The Reviewer believes that the chiropractic manipulation performed beyond 9-20-05 cannot be supported. The literature on manipulation clearly indicates there is a point of diminishing return. Most studies indicate a maximum therapeutic benefit around 9-18 sessions. The Official Disability Guidelines recommends against ongoing manipulation. Additionally, the documentation supplied fails to demonstrate inter-tester consistency regarding therapeutic benefit beyond 9-20-05. After reviewing the documentation from all the providers, it became apparent the patient made inadequate improvement in regards to pain, range of motion, strength, sensory testing, orthopedic testing, functional outcome questionnaires, tolerance with daily activities, or return to work tolerance.

Manual therapy (97140): The Reviewer believes the manual therapy performed beyond 9-20-05 cannot be supported. The Philadelphia Panel of Physical Therapy found insufficient evidence to support manual procedures in the treatment of neck pain or shoulder pain. The Official Disability Guidelines and ACOEM guidelines recommend against ongoing manual procedures in the treatment of neck and shoulder pain. This procedure reaches a point of diminishing return around 9-18 sessions. Additionally, there should be a reduction of passive procedures with emphasis on active exercise and a home program for self-sufficiency and independence within the initial 9-18 sessions. There is good peer-reviewed evidence to suggest excessive use of passive procedures commonly contributes to dependency and over-utilization.

Electrical stimulation (97032): The Reviewer believes in-office electrical stimulation was not reasonable or necessary at any point. The chiropractor prescribed a home electrical stimulation unit within the initial few sessions. Since the patient was performing this independently at home, I fail to see the medical justification for performing in-office electrical stimulation concurrently. Additionally, there is a lack of peer-reviewed medical literature to support electrical stimulation in the treatment of neck and/or shoulder pain > 8 weeks; therefore, the use of such a modality should be time-limited and reserved for the acute phase of care. This is consistent with ODG and ACOEM. In fact ACOEM indicates ongoing passive care risks dependency.

Electrodes (A4556): The prescribed electrodes were reasonable and medical necessary while the patient rented the electric stimulation unit for 9/20/05 and 10/12/05.

Neuromuscular re-education (E0745): The Reviewer believes electrical modalities were not reasonable or necessary.

Ultrasound (97035): The peer-reviewed literature demonstrates a lack of relevant clinical benefit with ongoing ultrasound. The use of ultrasound in the treatment of neck pain and/or shoulder pain should be limited to the acute phase of care (6-8 weeks) for the dates 9/8/05 and 9/16/05.

Therapeutic exercise (97110), therapeutic activities (97530), and neuromuscular reeducation (97112): After a close review of the chiropractic exercise documentation, the reviewer believes the billing intensity of one-on-one guided rehabilitation can not be supported. The reviewer believes this is a case of over-utilization in regards to intensity of one-on-one guided exercise.

First, billing 1-1 services for recumbent bike, treadmill, and Airdyne cannot be medically justified. Second, the exercise logs did not include time in and time out to objective support the intensity billed. Third, the reviewer believes the rehabilitation program documented was not consistent with the intensity billed. Fourth, once a rehabilitation program has been successfully established, one-on-one services are not required and group codes should be used. One-on-one guidance is only indicated if the patient is experiencing difficulty performing the established exercises or the exercise program is adequately progressed from visit to visit to require additional instruction. The reviewer believes the documentation supports only 2 units of 1-1 supervised exercise per visit through 9-20-05. Therefore, 9/21/05 and beyond is not medical necessary.

The chiropractic care beyond 9-20-05 cannot be supported. The Official Disability Guidelines recommends 10 sessions of therapy over eight weeks for cervical disc herniations allowing for a fading of treatment frequency from three times per week to 1 or less plus a self-directed home program. This home program helps secure long-term benefits of therapy and establishes self-sufficiency and independence. The Official Disability Guidelines recommends 10 sessions of physical therapy following rotator cuff injuries allowing for a fading of treatment frequency plus a self-directed home program. In order to justify continuation of treatment, it is necessary to establish in a quantitative and objectively measurable manner that the treatment was efficacious. This improvement should be consistent throughout the documentation and there should be inter-tester consistency. The reviewer believes the documentation lacks inter-tester consistency regarding objective/functional therapeutic benefit as a result of the chiropractic treatment beyond 9-20-05. In fact, the chiropractic care failed to prevent ongoing disability, chronic pain syndrome, treatment dependency, interventional treatment (subacromial injections and 3 epidural steroid injections), and/or surgical intervention.

Screening Criteria

General:

In making his determination, the Reviewer had reviewed medically acceptable screening criteria relevant to the case, which may include but is not limited to any of the following: Evidence Based Medicine Guidelines (Helsinki, Finland); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Texas Chiropractic Association: Texas Guidelines to Quality Assurance (Austin Texas); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Mercy Center Guidelines of Quality Assurance; any and all guidelines issued by DWC or other State of Texas Agencies; standards contained in Medicare Coverage Database; ACOEM Guidelines; peer-reviewed literature and scientific studies that meet nationally recognized standards; standard references compendia; and findings; studies conducted under the auspices of federal government agencies and research institutes; the findings of any national board recognized by the National Institutes of Health; peer reviewed abstracts submitted for presentation at major medical associates meetings; any other recognized authorities and systems of evaluation that are relevant.

CERTIFICATION BY OFFICER

Clear Resolutions has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Clear Resolutions has made no determinations regarding benefits available under the injured employee's policy.

As an officer of Clear Resolutions Inc., I certify that there is no known conflict between the Reviewer, Clear Resolutions and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Clear Resolutions is forwarding by mail or facsimile, a copy of this finding to the DWC.

Sincerely,
Clear Resolutions Inc.



Chris Crow
President & Chief Resolutions Officer

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, 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 party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

I hereby certify, in accordance with DWC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent DWC via facsimile, U.S. Postal Service or both on this 4th day of October, 2006.

Name and Signature of Clear Resolutions Inc. Representative:

Sincerely,
Clear Resolutions Inc.

A handwritten signature in black ink, appearing to read "Chris Crow", with a long horizontal flourish extending to the right.

Chris Crow
President & Chief Resolutions Officer