



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: San Antonio Accident/Injury Care 401 W. Commerce # 100 San Antonio, Texas 78207 | MDR Tracking No.: M5-07-0506-01 (current MDR #) M4-05-8413-01 (former MDR #) |
| | Claim No.: |
| | Injured Employee's Name: |
| Respondent's Name and Address: Texas Hospital Insurance Exchange Rep Box # 06 | 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 "Treatment given to patient was medically necessary."

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 "This procedure is included in another procedure performed on same date of service. The services do not appear reasonable and/or necessary without further documentation..."

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) |
|----------------------|-------------------------------------------|---------------------------------------------------------------------|--------------------------------|
| 11-22-04 to 02-09-05 | 97124-GP, 97113-GP, 97530-GP and 97112-GP | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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.

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 01-11-2007, 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 97116-GP billed for dates of service 11-02-04, 11-04-04, 11-05-04, 11-08-04, 11-11-04, 11-12-04, 11-15-04, 11-17-04, 11-19-04, 11-22-04, 11-23-04, 12-06-04, 12-09-04, 12-13-04, 12-15-04, 12-17-04, 12-20-04, 12-21-04, 12-27-04, 01-03-05, 01-04-05, 01-11-05, 01-13-05, 01-14-05, 02-02-05, 02-03-05 and 02-09-05 was denied by the Respondent with denial code "97" (this procedure is included in another procedure performed on the same date of service), "W4" (previously recommended amount has not been changed) and "G" (this procedure is included in another procedure performed on the same date of service). **NOTE:** Dates of service 11-02-04 through 12-15-04 and dates 02-02-05, 02-03-05 and 02-09-05 denied with denial codes 97 and W4, date of service 12-17-04 denied with denial code 97 only and dates of service 12-20-04 through 01-14-05 denied with codes 97, W4 and G. Per Rule 134.202(b) CPT code 97116-GP is global to CPT code 97530-GP also billed on the dates of service in dispute. No reimbursement recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.1 and 134.202
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:

03-15-07

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 OF TEXAS

[IRO #5259]

10817 W. Hwy. 71
Phone: 512-288-3300

Austin, Texas 78735
FAX: 512-288-3356

NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISED 2/28/07

| | |
|--------------------------------------------------------|----------------------------------|
| TDI-WC Case Number: | |
| MDR Tracking Number: | M5-07-0506-01 |
| Name of Patient: | |
| Name of URA/Payer: | San Antonio Accident/Injury Care |
| Name of Provider: (ER, Hospital, or Other Facility) | San Antonio Accident/Injury Care |
| Name of Physician: (Treating or Requesting) | Rita Sealy, DC |

February 8, 2007

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on the Division of Workers' Compensation Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Division of Workers' Compensation

REVISED 2/28/07

DOCUMENTS REVIEWED

1. Notification of IRO Assignment, Table of Disputed Services, Carrier EOBs, copies of CMS-1500 billing forms
2. Employer's First Report of Injury or Illness, dated
3. Treating doctor's Initial Evaluation and Report, dated 10/21/04
4. Treating doctor's "Daily Treatment Logs," dates 12/6/04 through 1/14/05, and "Exercise Flow Sheets," and "Clinical Notes," multiple dates
5. Initial Consultation Report from orthopedic pain management specialist, dated 11/8/04
6. Follow-up reports from orthopedic pain management specialist, multiple dates
7. Carrier's required medical examination and report, dated 12/14/04
8. Treating doctor's "Letter of Disagreement" with above RME, dated 12/27/04

9. Letter of reconsideration for performance of a lumbar ESI, dated 1/20/04
10. Functional Capacity Evaluation, dated 12/9/04
11. EMG/NCV and report, dated 12/11/04
12. Lumbar spine MRI and report, dated 11/2/04
13. Initial Behavioral Medicine Consultation and report, dated 9/21/05
14. Designated doctor's report and TWCC-69 (stating not at MMI), dated 5/16/05
15. Statement of medical necessity for products and supplies from treating doctor of chiropractic, dated 5/31/05
16. Designated doctor examination and report (with TWCC-69), declaring patient was not yet at MMI, dated 11/29/05 and 12/2/05
17. Physical medicine and rehabilitation doctor's notes, dated 1/25/06
18. Carrier's medical records reviews, dated 10/31/05, 2/21/06 and 7/25/06
19. Carrier's medical records reviews (osteopathic), dated 2/14/05 and 6/13/05
20. Carrier's doctor of chiropractic record reviews, dated 1/7/05, 6/7/05 and 11/3/05
21. Lumbar myelogram and lumbar CT, with and reports (including operative report), dated 7/26/06
22. Properly executed "DWC Employee's Request to Change Treating Doctors" forms, dated 11/9/05 and 9/12/06
23. "Patient SOAP Notes" from new doctor of chiropractic, dated 9/20/06
24. Neurosurgeon's reports, dated 4/4/06 and 10/3/06
25. Pain management office visit notes, multiple dates
26. Various TWCC-73s

CLINICAL HISTORY

Patient is a 53-year-old male radiology technician who, on ____, was helping transfer a patient weighing an estimated 160 pounds from his wheelchair to the x-ray table when he felt/heard a "pop" in his lower back, accompanied by immediate onset of pain. Over the next 24 hours, the pain intensified and began radiating into both his legs. He initiated treatment with a doctor of chiropractic who prescribed chiropractic care, physical therapy and rehabilitation.

When his response to conservative care was less than desired, he then received a series of three epidural steroid injections, followed by post-injection physical therapy and rehabilitation.

REQUESTED SERVICE(S)

Massage therapy (97124), aquatic therapy (97113), neuromuscular reeducation (97112), and therapeutic activities (97530) for dates of service 11/22/04 through 2/9/05.

DECISION

Denied.

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) 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) 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. (D) Supporting documentation for additional treatment must be furnished when exceptional factors or extenuating circumstances are present. (E) 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 a lack of documentation of objective or functional improvement in this claimant's condition, and no evidence of a change of treatment plan to justify additional treatment in the absence of positive response to prior treatment. In fact, quite the opposite was true. Upon review of the treating doctor's narrative notes from 11/2/04, 11/4/04, 11/5/04, 11/15/04 and 11/17/04, comments such as "...has shown little progress..." and "...lower lumbar pain

bilaterally has not noticeably changed..." and "...the patient's condition remains the same as the previous visit" are repeated throughout. Despite the documented lack of progress or response, the treating doctor continued to perform and provide the same, unchanging treatment plan, and the *Guidelines for Chiropractic Quality Assurance and Practice Parameters* 1 Chapter 8 under "Failure to Meet Treatment/Care Objectives" states, "After a maximum of two trial therapy series of manual procedures lasting up to two weeks each (four weeks total) without significant documented improvement, manual procedures may no longer be appropriate and alternative care should be considered." Furthermore, the ACOEM Guidelines² that if treatment does not bring improvement in three to four weeks, it should be stopped and the patient reevaluated. By 11/22/04—the first date of service in this dispute—the literature suggests that this treatment protocol should have been discontinued.

In terms of the aquatic exercises (97113), there was nothing in the documentation that provided adequate rationale to explain and justify why this higher-level service was necessary, as opposed to a more standard, land-based regimen. And, insofar as the neuromuscular reeducation (97112) performed, 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 3, "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.

Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that I have no known conflicts of interest between the 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.

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.

Chief Clerk of Proceedings
Division of Workers' Compensation
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell

1 Haldeman, S; Chapman-Smith, D; Petersen, D *Guidelines for Chiropractic Quality Assurance and Practice Parameters*, Aspen Publishers, Inc.

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

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