

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP () IE () IC	Response Timely Filed? () Yes (X) No
Requestor Waco Ortho Rehab. Associates, LLC P.O. Box 2850 Bryan, TX 77805	MDR Tracking No.: M5-05-0613-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Texas Mutual Insurance Co. Rep. Box #54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: FEE DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
11-3-03	12-29-03	99212-25(9)	\$41.91	\$377.19
11-3-03	12-22-03	97139EU (16)	\$18.25	\$292.00
11-3-03	12-12-03	A4595 (2)	\$36.01	\$72.02
11-3-03	12-5-03	A9150 (3)	\$8.00	\$24.00
11-5-03	11-12-03	97024 (4)	\$5.53	\$22.12
11-7-03	11-7-03	99213-25	\$58.99	\$58.99
11-10-03	11-10-03	99211-25	\$23.35	\$23.35
11-18-03	11-18-03	98940	\$30.13	\$30.13
TOTAL DUE				\$899.80

G issue regarding office visits:

Office visit is not global to physical therapy services or supplies rendered on this date.

No EOB for supplies:

Neither party in the dispute submitted EOBs for some of the disputed services identified above. The requestor submitted convincing evidence that supports bills were submitted for audit. Since the insurance carrier did not raise the issue in their response that they had not had the opportunity to audit these bills and did not submit copies of the EOBs, the Medical Review Division will review these services per Rule 134.202.

PART III: MEDICAL NECESSITY DISPUTE

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution –General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 10-22-04.

The IRO reviewed massage, therapeutic procedure, therapeutic exercises, kinetic therapeutic procedures rendered from 11-12-03 through 12-29-03 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(q)(2)(C), the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

The IRO concluded that all treatment and services from 11-12-03 through 11-14-03 (97124) was medically necessary; A maximum of three units of therapeutic exercises each date of service in dispute from 11-17-03 through 11-21-03 were medically necessary (the insurance carrier already reimbursed the provider for 3 units); and all other treatment and services in dispute were not medically necessary in this case.

On this basis, the total amount recommended for reimbursement (\$25.69) does not represent a majority of the medical fees of the disputed healthcare and therefore, the requestor did not prevail in the IRO decision. Consequently, the requestor is not owed a refund of the paid IRO fee.

PART IV: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of \$899.80 for fee dispute and \$25.69 for medical necessity dispute. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Elizabeth Pickle, RHIA

May 5, 2005

Authorized Signature

Typed Name

Date of Order

PART V: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____

December 13, 2004

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-05-0613-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: IRO 5055

Dear Ms. ____:

IRI has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc. and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is licensed in chiropractic and is currently on the TWCC Approved Doctor List.

Sincerely,

Gilbert Prud'homme
Secretary & General Counsel

GP:thh

REVIEWER'S REPORT
M5-05-0613-01
10/13/04

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor:

- Summary of provider's position 11/30/04
- Initial interview 12/12/03
- Office notes 10/15/03 – 11/26/03
- Daily progress notes 10/15/03 – 12/29/03
- Therapeutic procedures 11/12/03 – 12/29/03
- Muscle testing 11/26/03 – 12/01/03

Clinical History:

Patient underwent physical medicine treatments after injuring her left wrist at work on ____.

Disputed Services:

Massage, therapeutic procedure, therapeutic exercises X1 unit, X1 unit, X1 unit, X4 units, X5 units, X3 units, X5 units, X1 unit, kinetics therapeutic procedure during the period of 11/12/03 thru 12/29/03.

Decision:

The reviewer partially disagrees with the determination of the insurance carrier and is of the opinion that all treatment and services from 11/12/03 through 11/14/03 was medically necessary. A maximum of three units of therapeutic exercises each date of service in dispute from 11/17/03 through 11/21/03 were medically necessary. All other treatment and services in dispute were not medically necessary in this case.

Rationale:

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." It is the position of the Texas Chiropractic Association 2 that it is beneficial to proceed to the rehabilitation phase (if warranted) as rapidly as possible, and to minimize dependency upon passive forms of treatment/care since studies have shown a clear relationship between prolonged restricted activity and the risk of failure in returning to pre-injury status. The TCA Guidelines also state that repeated use of acute care measures generally fosters chronicity, physician dependence and over-utilization and the repeated use of passive treatment/care tends to promote physician dependence and chronicity.

Based on those guidelines, the passive treatment during the first two weeks from 10/27/03 through 11/14/03 was indicated and medically necessary. However, continuation of passive treatment after two weeks was not indicated or medically necessary. Likewise, a maximum of 3 units of therapeutic exercises per date of service was indicated during the 4-week period that ended on 11/21/03, but not thereafter.

The continuation of treatment after 11/21/03 was also not indicated since it failed to fulfill the statutory requirements 3 for medical necessity by relieving the patient's pain, promoting recovery or enhancing the employee's ability to return to employment. Specifically, the patient's pain rating was 6/10 on 10/27/03 at the initiation of treatment and remained at the very 6/10 level after 4 weeks of treatment on 11/21/03. Moreover, the patient had not returned to employment and there were no objective findings to document that recovery had been promoted. Therefore, the medical necessity of continuing past unsuccessful treatment is not supported.

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

2 Quality Assurance Guidelines, Texas Chiropractic Association.

3 Texas Labor Code 408.021