

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## Retrospective Medical Necessity Dispute

### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (X) HCP ( ) IE ( ) IC	<b>Response Timely Filed?</b> (X) Yes ( ) No
Requestor's Name and Address  <b>Pain &amp; Recovery Clinic-North % Bose Consulting, LLC P.O. Box 550496 Houston, TX 77255</b>	MDR Tracking No.: M5-05-1890-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address  <b>Amcomp Assurance Corp, Box 34</b>	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

### PART II: SUMMARY OF DISPUTE AND FINDINGS – MEDICAL NECESSITY ITEMS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
3-8-04	3-18-04	CPT codes 99212, 97032, 97140, 97110, 97112, E1399	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3-18-04	4-14-04	CPT codes 99212, 99214	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3-22-04	4-16-04	CPT codes 99212 (only on 4-16-04), 97032, 97140, 97110, 97112, E1399	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

### PART III: 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 Commission Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Medical Review Division assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the requestor and respondent.

In accordance with Rule 133.308 (e), requests for medical dispute resolution are considered timely if they are filed with the division no later than one (1) year after the date(s) of service in dispute. The following date(s) of service are not timely and are not eligible for this review: 3-1-04 through 3-5-04.

The carrier states that some of the disputed services have been reimbursed. The requestor did not receive this payment.

The Division has reviewed the enclosed IRO decision and determined that the requestor did **not** prevail on the disputed medical necessity issues. The amount due the requestor for the medical necessity issues is \$2,081.18.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 5-5-05 the Medical Review Division 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.

Regarding CPT code 97110 on 3-26-04: Neither party submitted an EOB for this date of service (and did not timely respond to the request for additional information): Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. **Reimbursement not recommended.**

**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 not entitled to a refund of the paid IRO fee. The Division hereby **ORDERS** the insurance carrier to remit the amount of \$2,081.18, plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Donna Auby

7-21-05

Authorized Signature

Typed Name

Date of Order

**PART V: INSURANCE CARRIER DELIVERY CERTIFICATION**

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

Signature of Insurance Carrier: \_\_\_\_\_ Date: \_\_\_\_\_

**PART VI: 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.**

## Parker Healthcare Management Organization, Inc.

3719 N. Beltline Road, Irving, TX 75038  
972.906.0603 972.255.9712 (fax)  
Certificate # 5301

June 17, 2005  
Amended: July 20, 2005

**ATTN: Program Administrator**  
**Texas Workers Compensation Commission**  
Medical Dispute Resolution, MS-48  
7551 Metro Center Drive, Suite 100  
Austin, TX 78744  
Delivered by fax: 512.804.4868

### Notice of Determination

MDR TRACKING NUMBER: M5-05-1890-01  
RE: Independent review for \_\_\_\_

The independent review for the patient named above has been completed.

- Parker Healthcare Management received notification of independent review on 5.5.05.
- Faxed request for provider records made on 5.5.05.
- The case was assigned to a reviewer on 5.22.05.
- The reviewer rendered a determination on 6.15.05.
- The Notice of Determination was sent on 6.17.05.
- The Amended Notice of Determination was sent on 7.20.05.

The findings of the independent review are as follows:

#### Questions for Review

CPT codes 99212 (office visit est. pt.), 97032 (electrical stimulation), 97140 (Manual therapy technique), 97110 (Therapeutic exercise), 97112 (Neuromuscular re-education) and E1399 (DME) is being denied by the carrier. The carrier's denial reasoning stated a lack of medical necessity or a "U" code. The dates of service in dispute are 3.8.04 through 4.16.04.

#### Determination

PHMO, Inc. has performed an independent review of the proposed care to determine if the adverse determination was appropriate. After review of all medical records received from both parties involved, the PHMO, Inc. physician reviewer has determined to **overturn the denial** of all care rendered on and before 3.18.2004. The denial of the evaluation (99214) that occurred on 4.14.04 is also overturned. The denial of all E&M services (99212 and 99214) between 3.18.2004 – 4.14.2004 is overturned.

The denial regarding all care not specifically allowed hereinbefore is **upheld**.

## Summary of Clinical History

Mr. \_\_\_ sustained a work related injury on \_\_\_\_. The accident involved a fall off of scaffolding from about 10 feet in the air. Dr. G. Arango, D.C. diagnosed Mr. \_\_\_ with lumbar sprain/strain, lumbar segmental dysfunction, rib sprain strain and TMJ sprain/strain injury. Since the time of the injury, the patient has undergone various types of treatment and therapy and diagnostics. Care did change from G. Arango, D.C. to William Hicks D.C.

## Clinical Rationale

The patient started rehabilitative therapy and active care in the middle of January of 2004, and received monthly evaluations. The initial evaluation by Dr. Hicks occurred on 1.21.04. A course of care was prescribed and fulfilled. The subsequent evaluation on 2.2.04 revealed VAS scores, subjective complaints and objective findings that were virtually unchanged. ODG and ACEOM criteria notwithstanding, two weeks is not a sufficient trial to determine the efficacy of a treatment plan. Therefore, the referral for additional care was medically appropriate.

The evaluation on 2.11.04 also revealed findings that were virtually unchanged from the previous 2 evaluations. The VAS score remained 8 out of 10. The findings were similar. The plan was unchanged, except for an orthopedic consult. The AROM of the C-Spine demonstrated mild – moderate restrictions. Since this evaluation was performed within the first 6 weeks of care, a referral for continued care for the lower back is not unreasonable. Dr. Hicks made the appropriate referral for consideration of additional intervention.

The evaluation on 3.15.04 again revealed VAS scores that were specific to the region. Progress appears to have been made in the patient's Cervical Spine with regards to his AROM. The limitations appear to be symptoms at the end ranges. However, there is no documented improvement of the patient's lower back condition. In the absence of any progress in his lower back, an additional referral for a full range of physiotherapy services was not appropriate. However, since some progress was made at least in the patient's Cervical Spine, an allowance for continued care beyond 3.15.04 is medically appropriate.

The 4.14.04 evaluation revealed the previous prescription of physiotherapy did not significantly improve the patient's condition. The daily notes document the VAS score consistently being in the 6 -7 range during the course of care. Of note, the E&M services offered during the daily visits were coded as 99212. This represents a more focused visit, versus a visit sufficient to allow the provider to more completely reassess the patient's condition. Since this lower level of service was offered, it was reasonable to continue care from one evaluation to the next without interruption or significant alteration.

Although the full range of care probably should have been curtailed after the 3.15.04 evaluation, I will defer (for this one issue only) to the opinion of Dr. Buczek, the carrier-selected reviewer, who opined that care should be offered until 3.18.04. I disagree with Dr. Buczek's assertion that Dr. Hicks should not serve as the treating provider. The evaluation records reveal that Dr. Hicks made referrals when necessary for appropriate diagnostics and surgical/pain management intervention. As such, the records seem to indicate that he fulfilled his responsibilities as treating doctor.

Beyond 3.18.04, the E&M services, reevaluations and one unit of therapeutic activity would be appropriate to improve the patient's cervical spine until 4.14.04. Although such care was evidently not successful, the care had the reasonable expectation to improve his condition.

Of note, an FCE performed late in 2004 revealed the patient to be capable of sedentary work demands. The designated doctor felt the patient was not at MMI, and noted a VAS score consistent with Dr. Hick's evaluations. Other providers who participated in the care of the patient also reported unchanged subjective complaints.

## Clinical Criteria, Utilization Guidelines or other material referenced

- *Occupational Medicine Practice Guidelines*, Second Edition.
- *The Medical Disability Advisor*, Presley Reed M.D.
- *A Doctors Guide to Record Keeping*, Utilization Management and Review, Gregg Fisher

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The reviewer for this case is a doctor of chiropractic peer matched with the provider that rendered the care in dispute. The reviewer is engaged in the practice of chiropractic on a full-time basis.

The review was performed in accordance with Texas Insurance Code §21.58C and the rules of the Texas Workers Compensation Commission. In accordance with the act and the rules, the review is listed on the TWCC's list of approved providers, or has a temporary exemption. The review includes the determination and the clinical rationale to support the determination. Specific utilization review criteria or other treatment guidelines used in this review are referenced.

The reviewer signed a certification attesting that no known conflicts-of-interest exist between the reviewer and any of the providers or other parties associated with this case. The reviewer also attests that the review was performed without any bias for or against the patient, carrier, or other parties associated with this case.

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I hereby verify that a copy of this Findings and Decision was faxed to TWCC, Medical Dispute Resolution department applicable to Commission Rule 102.5 this 17<sup>th</sup> day of June, 2005. The TWCC Medical Dispute Resolution department will forward the determination to all parties involved in the case including the requestor, respondent and the injured worker. Per Commission Rule 102.5(d), the date received is deemed to be 5 (five) days from the date mailed and the first working day after the date this Decision was placed in the carrier representative's box.

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Meredith Thomas  
Administrator  
Parker Healthcare Management Organization, Inc.

CC:

Pain and Recovery c/o Bose Consulting

AMCOMP Assurance Corp.

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