

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP () IE () IC	Response Timely Filed? () Yes (X) No
Requestor's Name and Address Ed Kieke, D.C. 1600 Smith Suite # 4225 Houston, Texas 77002	MDR Tracking No.: M5-05-1965-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Insurance Company of the State of PA Box 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
03-15-04	07-02-04	97110, 97112, 97032, 97035, 98940, 98941, 98943, 97140, 99272, 97010	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
			<input type="checkbox"/> Yes <input 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.

Per Rule 133.308(e)(1) date of service 03-08-04 was not timely filed and was not part of the review.

Per Rule 134.202(b) codes 99213-MP, 97750-25 and 97112-25 were not valid for Medicare and were not part of the review.

The Division has reviewed the enclosed IRO decision and determined that the requestor did **not** prevail on the disputed medical necessity issues.

PART IV: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review 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:

Debra L. Hewitt

06-13-05

Authorized Signature

Typed Name

Date of Decision

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 en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

Phone: 512-402-1400

FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-05-1965-01
Name of Patient:	
Name of URA/Payer:	Ed Kieke, DC
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Ed Kieke, DC

June 10, 2005

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 Texas Workers' Compensation Commission 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: Texas Workers Compensation Commission

CLINICAL HISTORY

Available information suggests that this patient reports experiencing left ankle, hip and back injury as a result of a fall at work on _____. Initial x-rays and MRI proximal to the event are found essentially unremarkable. The patient appears to be treated conservatively by a Minh-Hang Chu, MD for uncomplicated sprain/strain conditions. The patient begins treatment with chiropractors, Mary Ann Spires, DC and Ed Kieke, DC, on or about 02/13/04 (1+ year post injury). Chiropractic treatment appears to consist of multiple passive and active modalities but no specific documentation of these is provided for review. There are multiple chiropractic 'patient daily records' beginning 03/08/04 that appear to check off modalities applied without DOP, specific plan of care or rationale for specific treatment applications. No chiropractic narrative reporting is provided for review. Chiropractic treatment appears to continue essentially unchanged through 07/02/04.

REQUESTED SERVICE(S)

Determine medical necessity for therapeutic exercise (97110), neuromuscular reeducation (97112), manual electric stimulation (97032), manual therapy (97140) confirmatory consultation (99272) and hot/cold pack (97010) for period in dispute 03/15/04 through 07/02/04.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

Medical necessity for these ongoing treatments and services (03/15/04 through 07/02/04) **are not supported** by available documentation. Ongoing therapeutic modalities of this nature suggest little potential for further restoration of function or resolution of symptoms at 1+ year post injury. With limited chiropractic documentation available, these ongoing services [therapeutic exercise (97110), neuromuscular reeducation (97112), manual electric stimulation (97032), manual therapy (97140) confirmatory consultation (99272) and hot/cold pack (97010)] at this late date, do not appear to be reasonable and customary for conditions of this nature.

1. Philadelphia Panel Evidence-Based Clinical Practice Guidelines on Selected Rehabilitation Physical Therapy, Volume 81, Number 10, October 2001.

2. Hurwitz EL, et al. The effectiveness of physical modalities among patients with low back pain randomized to chiropractic care: Findings from the UCLA Low Back Pain Study. *J Manipulative Physiol Ther* 2002; 25(1):10-20.
3. Bigos S., et. al., AHCPR, Clinical Practice Guideline, Publication No. 95-0643, Public Health Service, December 1994.
4. Harris GR, Susman JL: "Managing musculoskeletal complaints with rehabilitation therapy" *Journal of Family Practice*, Dec, 2002.
5. Morton JE. Manipulation in the treatment of acute low back pain. *J Man Manip Ther* 1999; 7(4):182-189.
6. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Mercy Center Consensus Conference, Aspen Publishers, 1993.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials.

No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned individual. These opinions rendered do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.