

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP () IE () IC	Response Timely Filed? (X) Yes () No
Requestor's Name and Address Allied Multicare Centers 415 Lake Air Drive Waco, Texas 76710	MDR Tracking No.: M5-05-2092-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address American Home Assurance Company 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		
04-01-04	12-15-04	97124, G0283, 97024, 98940, 97012, 99213 and 99212	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
11-12-04	11-12-04	97024-GP	<input checked="" type="checkbox"/> Yes <input 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.

The requestor submitted a withdrawal for CPT code 95831 date of service 07-20-04 on 05-04-05.

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, 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 05-17-05, 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.

CPT code 97024-GP date of service 11-12-04 denied with denial code "N/205" (this code was disallowed as additional information/definition is required to clarify service/supply rendered). The requestor submitted documentation to support delivery of service per Rule 133.307(g)(3)(A-F). Reimbursement is recommended in the amount of **\$6.99**.

PART IV: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor **is** entitled to reimbursement for CPT code 97024-GP date of service 11-12-04 totaling \$6.99 and is not entitled to a refund of the paid IRO fee. The Division hereby **ORDERS** the insurance carrier to remit this amount and the appropriate amount for the services in dispute consistent with the applicable fee guidelines, plus all accrued interest due at the time of payment, to the Requestor within 20-days of receipt of this Order.

Ordered By:

Debra L. Hewitt

06-13-05

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.



7600 Chevy Chase, Suite 400
Austin, Texas 78752
Phone: (512) 371-8100
Fax: (800) 580-3123

NOTICE OF INDEPENDENT REVIEW DECISION

Date: June 9, 2005

To The Attention Of: TWCC
7551 Metro Center Drive, Suite 100, MS-48
Austin, TX 78744-16091

RE: Injured Worker: _____
MDR Tracking #: M5-05-2092-01
IRO Certificate #: 5242

Forté has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractic reviewer who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- Initial narrative report
- Amended narrative report
- Subsequent medical reports
- MRI reports
- Electrodiagnostic reports
- FCE reports
- Daily notes

Submitted by Respondent:

- TWCC forms
- Medical reports
- Subsequent medical reports
- Peer review analysis of the therapy rendered
- Daily notes
- Work hardening notes
- Psychotherapy progress notes
- Biofeedback therapy notes

Clinical History

According to the supplied documentation, the claimant sustained an injury on ___ while descending a ladder. The claimant reported when he stepped down he felt an immediate sharp pain in his lower back. The claimant was initially seen by Dr. Lamanza on 10/7/03. The claimant then sought care with Ron Landerman, D.C. on 10/13/03. Dr. Landerman diagnosed the claimant with a lumbar sprain/strain Grade II, lumbar facet syndrome, sciatica right, and myofascial pain syndrome. The claimant was removed from the work place and began passive chiropractic therapy. On 11/7/03 an MRI of the lumbar spine was performed which revealed L5/S1 diffuse disc desiccation and mild broad based disc protrusion. No obvious neural encroachment was seen. On 1/13/04 an EMG/NCV was performed that revealed no evidence of radiculopathy or compression neuropathy by this study. The report also stated that there is evidence of subtle peripheral neuropathy seen in this study, again, this is very mild. On 4/14/04 the claimant underwent a second lumbar spine MRI that revealed an L5/S1 diffuse annular bulge with mild disc desiccation, not significantly changed since the previous study. The claimant continued passive therapies. The claimant underwent work conditioning as well as work hardening programs. The documentation ends here.

Requested Service(s)

97124 massage therapy, G0283 electrical stimulation, 97024 diathermy, 98940 chiropractic manipulative treatment - spinal, 97012 mechanical traction, 99213 office visit, 99212 office visit for dates of service 4/1/04 through 12/15/04

Decision

I agree with the insurance carrier that the services in dispute were not medically necessary.

Rationale/Basis for Decision

The objective documentation supplied reveals that the claimant sustained a sprain/strain to his lumbar spine. The two MRI reports reveal existing disc desiccation which is unrelated to the injury but could contribute to the healing process. The amount of therapy rendered between October 2003 through March 2004 would have been an adequate trial of conservative care to help improve the claimant. At this time it would have been necessary to change the claimant's treatment protocol to better assist him in returning to the work place. The conditioning/hardening programs the claimant underwent appear to be reasonable and medically necessary to treat the compensable injury. Ongoing passive therapies appear to be redundant and are not objectively supported with the documentation supplied. According to the Official Disability Guidelines Special Edition of the Top 200 Conditions (page 213), the chiropractic guidelines for a lumbar sprain/strain ICD-9 Code 847.2 report with a severe strain and with evidence of objective functional improvement, a total of up to 18 visits over 6-8 weeks, avoid chronicity. The therapy done in the initial 6 months of treatment appear over and beyond these current treatment protocols and appear to be an adequate amount of therapy rendered. On 12/30/03 Joel G. Freitag, M.D. performed a neurological consultation on the claimant and reported that the diffuse disc desiccation at L5/S1 was insignificant. The disputed services are all passive in nature and are not medically supported.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 9th day of June 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder