

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 Daniel's Chiropractic 3250 W. Pleasant Run Road Suite 130 Lancaster, Texas 75146	MDR Tracking No.: M5-05-2103-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Box 43	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		
03-29-04	07-12-04	Office visits, chiropractic manipulation, electrical stimulation, vasopneumatic devices, prolonged physical services- outpatient setting, medical conference by physician and manual therapy technique.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
03-29-04	06-07-04	99080-73	<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 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 04-28-05, 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 99080-73 on dates of service 03-29-04, 04-05-04, 04-12-04, 04-19-04, 05-03-04, 05-10-04, 05-17-04, 05-25-04, 06-01-04 and 06-07-04 denied with denial code "U" (unnecessary medical treatment without peer review). The TWCC-73 per Rule 129.5 is a required report and not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. Reimbursement is recommended in the amount of **\$150.00 (\$15.00 X 10 DOS)**. A Compliance and Practices referral will be made due to the carrier being in violation of Rule 129.5.

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 a refund of the paid IRO fee. The Division hereby **ORDERS** the insurance carrier to remit the appropriate amount totaling **\$150.00** 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.

Findings and Decision and Order By:

Debra L. Hewitt

06-17-05

Authorized Signature

Typed Name

Date of Decision and Order

PART V: INSURANCE CARRIER DELIVERY CERTIFICATION

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

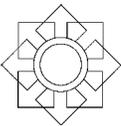
Signature of Insurance Carrier: _____ Date: _____

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.



Texas Medical Foundation

Barton Oaks Plaza Two, Suite 200 • 901 Mopac Expressway South • Austin, Texas 78746-5799
phone 512-329-6610 • fax 512-327-7159 • www.tmf.org

NOTICE OF INDEPENDENT REVIEW DECISION

June 9, 2005

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker: _____
MDR Tracking #: M5-05-2103-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) 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 TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered 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 matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. TMF's health care professional 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 TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 51 year-old male injured his neck, lower back and left knee on ____ when he slipped and fell to the floor. He has been treated with medications and therapy.

Requested Service(s)

Office visit, established patient, chiropractic manipulation, electrical stimulation, vasopneumatic devices, prolonged physical services, outpatient setting, medical conference by physician, manual therapy technique for date of service 03/29/04 through 07/12/04

Decision

It is determined that there is no medical necessity for the office visit, established patient, chiropractic manipulation, electrical stimulation, vasopneumatic devices, prolonged physical services, outpatient setting, medical conference by physician, and manual therapy technique for date of service 03/29/04 through 07/12/04 to treat this patient's medical condition.

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. The frequency, type and duration of services must

be reasonable and consistent with the standards of the health care community. Medical record documentation does not indicate that the disputed services fulfilled statutory requirements¹ for medical necessity since the patient obtained no significant relief of pain, promotion of recovery, or enhancement of the employee's ability to return to employment.

While the provide used NASS² as a basis for the ongoing passive therapy, those guidelines indicate that passive interventions are indicated during the first 8 weeks only, "if clinically indicated and not previously unsuccessful." After 8 weeks, the NASS guidelines recommend that passive treatment be decreased. The disputed passive treatments in this case were rendered well after the 8 week period and had been previously unsuccessful. Therefore, the office visit, established patient, chiropractic manipulation, electrical stimulation, vasopneumatic devices, prolonged physical services, outpatient setting, medical conference by physician, and manual therapy technique for date of service 03/29/04 through 07/12/04 were not medically necessary to treat this patient's medical condition.

Sincerely,



Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:dm

Attachment

Attachment

Information Submitted to TMF for TWCC Review

Patient Name: ____

TWCC ID #: M5-05-2103-01

Information Submitted by Requestor:

- Progress Notes

Information Submitted by Respondent:

- Progress Notes
- Required Medical Evaluation
- Designated Doctors Evaluation
- Diagnostic Tests
- Claims

¹ Texas Labor Code 408.021

² North American Spine Society phase III clinical guidelines for multidisciplinary spine care specialist.2000