

# 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>Richard Stephenson, D. C.</b> <b>322 North Main St.</b> <b>Bryan, TX 77803</b>	MDR Tracking No.: <b>M5-05-2105-01</b>
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Liberty Mutual Fire Insurance, Box 28	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		
11-8-04	11-15-04	CPT codes 97035, 97124, G0283, 95900, 95904, 95934, 99213	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
			<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 **prevailed** on the disputed medical necessity issues.

### 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 a refund of the paid IRO fee in the amount of \$460.00. 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. The total amount for medical necessity items is \$1,136.22.

Ordered by:

Donna Auby

6-20-05

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 en 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

**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: M5-05-2105-01  
RE: Independent review for \_\_\_\_

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

- Parker Healthcare Management received notification of independent review on 4.27.05.
- Faxed request for provider records made on 4.27.05.
- TWCC issued Order for Payment on 5.11.05.
- The case was assigned to a reviewer on 5.23.05.
- The reviewer rendered a determination on 6.14.05.
- The Notice of Determination was sent on 6.17.05.

The findings of the independent review are as follows:

## Questions for Review

The items in dispute at this time are 97035 (Ultrasound), 97124 (Massage Therapy), Office visits, G0283 (Electrical stimulation), 95900 (Nerve Conduction Study with no F wave), 95904 (Nerve Conduction study – sensory), 95934 (H-Reflex study). All of the aforementioned is being denied with a “V” code for medical necessity. The dates of service that are listed in dispute are 11.8.04 through the date of 11.15.04.

## 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** on all denied services.

## Summary of Clinical History

The aforementioned claimant was injured on \_\_\_\_, while employed with \_\_\_\_ Mr. \_\_\_\_ was injured while delivering some sheetrock up some stairs, when he felt a pop in his lower back.

## Clinical Rationale

The patient apparently received chiropractic care from Lloyd Chiropractic for a period of 2 months. Additionally, the documentation reveals physical therapy was performed shortly after the injury. The note dated 3.4.2004 from Bill Gray, PA-C reported, “Due to his failure to improve more, even in light of physical therapy, which he has been very compliant with....”

Dr. Stephenson’s records do indicate subjective improvement of symptoms during the range of visits offered for review. The 11.08.04 note describes “mild to moderate (grade 3) lower back and tailbone pain.” The dates of service following this describe only mild pain (grade 1.) It is reasonable to conclude that Dr. Stephenson’s care resulted in the decreased symptoms.

Objectively, the notes dated 10.22.04 and 10.27.04 report “loss of muscle strength in the lower back and right leg.” The notes also report the following positive objective findings and signs: Miner’s, Ely’s, Kemp’s, Neris, Lewin’s, Psoas, and FABRE. Although the later notes do not speak to resolution of those findings, they include only 4 of the original 7. Additionally, the loss of muscle strength was later reported to be “mild loss of muscle strength.”

Dr. Lloyd did note LLE weakness in a 3.4.04 evaluation that was performed. This is not consistent with Dr. Stephenson’s finding of RLE weakness 8 months later. However, Dr. Lloyd’s findings preceded an

“unsuccessful” (as described by both Dr. Stephenson and the peer reviewer) trial of chiropractic care, and a considerable amount of time passed between the two evaluations.

Overall, Dr. Stephenson’s care appears to have been somewhat effective. Dr. Stephenson did personally perform an electrodiagnostic study. The study concluded the problem was discogenic in nature, therefore ongoing care would probably not resolve the condition.

It is my opinion that Dr. Stephenson’s care did result in a reduction of subjective and objective findings. Thus, the care rendered after the initial gains were made had the realistic expectation of further improving the patient’s condition. Therefore, the care was medically necessary.

Dr. Stephenson’s treatment plan appears brief and efficient. While I agree with the reviewer that this case appears chronic, Dr. Stephenson’s use of passive-only modalities was not extended and was associated with some degree of recovery for the patient.

The NCV was medically necessary due to symptoms that the claimant was experiencing. A needle-EMG was not provided for review. This would have been helpful in evaluating the patient’s radicular symptoms. The necessity for the electrodiagnostic studies does meet the criteria set in the AAEM guideline for medical necessity as demonstrated in the documentation provided for review.

## Clinical Criteria, Utilization Guidelines or other material referenced

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

---

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.

### 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 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 Tex. Admin. Code § 148.3). This Decision is deemed received by you 5 (five) days after it was mailed and the first working day after the date this Decision was placed in the carrier representative’s box (28 Tex. Admin. Code § 102.5 (d)). A request for hearing should be sent to: Chief Clerk of Proceeding/Appeals , 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 this written request for a hearing to the opposing party involved in the dispute.

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.

---

Meredith Thomas  
Administrator  
Parker Healthcare Management Organization, Inc.

CC:

Richard Stephenson, D.C.

Liberty Mutual Fire Insurance

---