

# 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> ( ) Yes (X) No
Requestor's Name and Address Charles A. Scott, D.C. 1516 N. Grandview Odessa, Texas 79761	MDR Tracking No.: M5-05-2175-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Texas Mutual Insurance Company Box 54	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		
09-09-04	11-11-04	97780, 99211, 98940, 97032 and 97124	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
			<input 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 06-17-2005, 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 97780 dates of service 09-27-04, 09-29-04, 09-30-04 and 10-04-04 was denied by the carrier with denial code F/893/973 (invalid code/modifier deleted from the Texas Fee Schedule or Fee Guideline MAR reduction). Per Ingenix.Encoder.Pro code 97780 was deleted (replaced) in 2005, however was valid in 2004. If acupuncture (97780) is billed with electrical stimulation (97032) it should be billed as 97781. No reimbursement recommended.

CPT code 97124 dates of service 11-10-04, 11-11-04, 11,16-04 and 11-17-04 denied with denial code F/435 (Fee Guideline MAR reduction/the value of the procedure is included in the value of the comprehensive procedure. The carrier per Rules 134.202(a)(4) and 133.304(c) did not specify which code 97124 was comprehensive to. Reimbursement is recommended in the amount billed by the requestor of **\$75.32 (\$18.83 X 4 DOS)**.

CPT code 97112 dates of service 11-10-04, 11,16-04 and 11-17-04 denied with denial code F/435 (Fee Guideline MAR reduction/the value of the procedure is included in the value of the comprehensive procedure. The carrier per Rules 134.202(a)(4) and 133.304(c) did not specify which code 97112 was comprehensive to. Reimbursement is recommended in the amount of **\$102.90 (\$34.30 X 3 DOS)**.

Review of CPT code 97750-FC date of service 10-19-04 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing evidence of carrier receipt of the providers request for an EOB. No reimbursement is 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 entitled to reimbursement for services totaling \$178.22 involved in this dispute. 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 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:

\_\_\_\_\_  
Authorized Signature

07-19-05  
\_\_\_\_\_  
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.**



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

## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** July 15, 2005

**To The Attention Of:**

TWCC  
7551 Metro Center Drive, Suite 100, MS-48  
Austin, TX 78744-16091

**RE: Injured Worker:**

**MDR Tracking #:** \_\_\_\_\_ M5-05-2175-01

**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/Physical Medicine reviewer (who is board certified in Physical Medicine) 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:**

- Notes by Charles Scott, D.C.
- NCV study report by Dr. Scott
- EMG by Richard Newman, M.D.
- Follow up notes by Bryan Murrell, M.D.
- MRI report
- Progress notes
- Physical therapy notes
- FCE
- Billing

**Submitted by Respondent:**

- None submitted

**Clinical History**

This claimant has a date of injury of \_\_\_\_ while working. On 1/9/04 he underwent a lumbar spine MRI which was absolutely normal. It appears approximately 33 treatment session notes are present during the disputed dates of service by Dr. Scott for

complaints of persistent low back pain and left lower extremity complaints. Charges on each session appear to be a follow up visit, manipulation, stimulation, massage and acupuncture. Studying the notes that are present by Dr. Scott, the claimant's pain level never really changes. It is stated at the beginning at 5/10 and during the last session on 12/8/04 is still 5/10. The claimant is taken off work by Dr. Scott on 9/8/04 through 12/17/04 for work conditioning. On 9/17/04 NCV study performed by Dr. Scott reports on the F-wave there is a tibial asymmetry which is indicative of S1 nerve root involvement. Dr. Scott does not perform the EMG. The EMG is then performed on 9/20/04 by Richard Newman, M.D. and this suggests a possible left S1 radiculopathy. The claimant is followed by Bryan Murrell, M.D. on 9/17/04 with left sacroiliac joint pain and decreased sensitivity to the left thigh. Diagnosis is lumbalgia secondary to mechanical low back pain from left sacroiliac joint arthropathy. Medicines are given of Vioxx, Ambien and AcipHex. He continues to follow with Dr. Murrell. On 10/15/04, medications are given. Diagnosis is now lumbalgia secondary to mechanical low back pain with left lateral femoral cutaneous neuropathy. He has a functional capacity evaluation on 10/19/04. It is classified at light-medium level and work hardening is recommended through the same facility. There are work conditioning notes on 12/6/04 where he is in his second week of this work conditioning program. This patient is a 34-year-old male who is 5'11" in height and 186 pounds.

### **Requested Service(s)**

97780 acupuncture, 99211 office visit, 98940 chiropractic manipulative treatment - spinal, 97032 electrical stimulation, 97124 massage therapy for dates of service 9/9/04 through 11/11/04

### **Decision**

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

### **Rationale/Basis for Decision**

After review of the records, this patient evidently suffered some sort of sprain/strain on \_\_\_ while working and has an essentially perfect MRI, yet continues to complain of low back pain and continues to be treated. It is my opinion this far from the reported date of injury to be performing passive modalities is not necessary nor standard of care. According to the US Department of Health and Human Services Guidelines they recommend 12 sessions of physical therapy at the beginning of an injury with a maximum of three modalities per session. At the end of this time the patient must show significant improvement to continue ongoing conservative care. According to the notes reviewed by Dr. Scott, the patient's pain level is unchanged at 5/10 and last note is 5/10. Pain level does go down to 4/10 occasionally, but never holds or stays down over this course of treatment. Therefore, there is lack of any documentation of any advancement in his pain complaints. It is usual and customary that an office visit is not charged when therapy modalities are being provided. After review of the records, it is my opinion that treatment from 9/9/04 thru 11/11/04, any conservative ongoing care this far from the injury date is not medically indicated, necessary, nor the standard of care. He should be independent in a self home program and structured chiropractic care is not necessary. I would deny all treatment for the 9/9/04 to 11/11/04 and further conservative care that has been rendered after that date.

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 15<sup>th</sup> day of July 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder