

# 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 Houston Pain & Recovery C/o Bose Consulting, LLC P O BOX 550496 Houston, Texas 77255	MDR Tracking No.: M5-05-2185-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Bituminous casualty Corporation C/o Harris & Harris Box 42	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		
04-13-04	07-15-04	99212 dates of service 04-20-04, 05-21-04 and 07-15-04	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
04-13-04	07-15-04	95900, 95904, 95934 and 95903	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
94013094	07-15-04	99211, 99212 (with the exception of dates of service listed above), 99213, 99214, 97032, 97035, 97116, 97150, E1399, 97140, 97110, 98940 and 97112	<input type="checkbox"/> Yes <input checked="" 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 **majority** of disputed medical necessity issues. The amount of reimbursement due from the carrier for the medical necessity issues equals **\$800.45**.

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 06-23-2005, 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 99080-73 dates of service 06-04-04 and 06-17-04 denied with denial code "V" (unnecessary treatment with peer review). Per Rule 129.5 the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. Reimbursement is recommended in the amount of **\$30.00**.

**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 services involved in this dispute totaling \$830.45. The requestor 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.

Findings and Decision and Order by:

07-25-05

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

\_\_\_\_\_  
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

**Original Date:** July 18, 2005

**Amended Date:** July 22, 2005

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

**RE: Injured Worker:** \_\_\_\_\_  
**MDR Tracking #:** M5-05-2185-01  
**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:**

- Position statement letter
- MRI of the lumbar spine report
- FCE reports
- Orthopedic consult notes
- EMG/NCV results
- Operative reports
- Physical therapy notes
- Progress notes
- Daily SOAP notes

### **Submitted by Respondent:**

- Statement letter from the carrier's counsel
- TWCC forms
- Table of disputed services
- Peer review reports

- Daily SOAP notes
- TWCC-73 forms
- FCE forms
- Radiology reports
- EMG/NCV reports

### **Clinical History**

According to the supplied documentation, the claimant sustained a work injury on \_\_\_ when the claimant was hit from behind by a log. The claimant was knocked out of the tree. The claimant was taken to Huntsville Memorial Hospital where cervical and lumbar x-rays were taken that revealed no fractures. The claimant began physical therapy. The claimant was also being treated by a chiropractor. On 9/26/03 the claimant underwent an MRI of the lumbar spine without gadolinium which was considered normal at all levels. On 4/27/04 the claimant underwent an EMG/NCV of the lower extremities which was determined to be normal. On 4/29/04 Omar Vidal, M.D. performed transforaminal epidural steroid injections bilaterally at L5/S1. Chiropractic therapy continued. The documentation ends here.

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

Office visits – 99211/99212/99213/99214, electrical stimulation (manual) – 97032, ultrasound – 97035, gait training – 97116, group therapeutic procedures – 97150, DME – E1399, manual therapy technique – 97140, therapeutic exercises – 97110, nerve conduction no F wave – 95900, nerve conduction sensory – 95904, H reflex study – 95934, motor nerve conduction test – 95903, chiropractic manipulative treatment – 98940 and neuromuscular re-education – 97112 for dates of service 4/13/04 through 7/15/04

### **Decision**

I disagree with the carrier and find that the office visits (99212) dated 4/20/04, 5/21/04, and 7/15/04 were medically necessary. I also agree that the NCV/EMG test was medically necessary (95900, 95904, 95934 and 95903). I agree with the carrier that the remainder of the services in dispute were not medically necessary.

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

According to the supplied documentation, the claimant sustained an injury to his lumbar spine on \_\_\_\_. The claimant went through a large amount of chiropractic and physical therapy during the following months. An MRI dated 9/26/03 revealed no abnormalities. An EMG/NCV performed in April 2004 also was negative for any abnormalities. The claimant was seen by Kenneth G. Berliner, M.D. for evaluation who diagnosed the claimant with a lumbar strain. Dr. Berliner noted that based on the claimant's MRI findings and clinical exam findings he could not find anything that would explain his persistent pain. The objective documentation does not support continued and redundant therapy that provided little relief for the claimant. With the negative MRI, then negative EMG/NCV tests, the diagnosis would be limited to a simple sprain/strain. An initial 12 weeks of active and passive modalities are seen as reasonable and medically necessary to treat the compensable claim. Continued and ongoing passive and active modalities beyond 12 weeks were not objectively supported by any of the documentation nor by the objective diagnostic testing that occurred in this case. If the claimant continued to have pain, then referrals to other doctors are seen as reasonable and medically necessary, therefore supporting the office evaluations on a monthly basis of 99212.

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 22<sup>nd</sup> day of July 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder