

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 Houston Pain and Recovery Clinic % Bose Consulting, L. L. C. P. O. Box 550496 Houston, Texas 77255	MDR Tracking No.: M5-05-2186-01
	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		
8-6-04	9-24-04	CPT codes 99211, 99212, 97032, 97035, 97112, 97116 , 97110	<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 disputed medical necessity issues.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were not the only fees involved in the medical dispute 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 5-13-05 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 codes 99213, 97032, 97035, 97110, 97140, E1399, 99212, 98940, 97112, 99080-73 from 4-30-04 through 9-24-04 (except as noted below) were denied by the carrier as "247-Evidence does not support the need for the duration, intensity and/or services billed." Per Rule 133.307 (g)(B) the additional documentation that the requestor must submit shall include "pertinent medical records or other documents relevant to the fee dispute." The office notes submitted do not meet the documentation criteria set forth by the descriptors for the above listed CPT Codes.

Recommend no reimbursement.

CPT code 99213 on 5-6-04 was denied as "247 - Evidence does not support the need for the duration, intensity and/or services billed." The requestor has submitted additional documentation per Rule 133.307(g)(B) supporting delivery of service. **Recommend reimbursement of \$67.25.**

CPT code 99212 on 7-15-04 was denied as "247 - Evidence does not support the need for the duration, intensity and/or services billed." The requestor has submitted additional documentation per Rule 133.307(g)(B) supporting delivery of service. **Recommend reimbursement of \$48.03.**

PART IV: COMMISSION DECISION

The Division hereby **ORDERS** the insurance carrier to remit \$115.28 for the office visits on 5-6-04 and 7-15-04 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 requestor is not entitled to a refund of the paid IRO fee.

Decision and Order By:

Donna Auby

7-12-05

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.

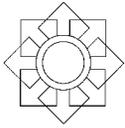
Signature of Insurance Carrier: _____ Date: _____

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.



Texas Medical Foundation

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NOTICE OF INDEPENDENT REVIEW DECISION

June 29, 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 #: M5-05-2186-01
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 41 year-old female injured her left shoulder and elbow on ___ while trying to apprehend two men that were attempting to steal from her place of employment. She was grabbed by one of the men and thrown into the cart she was driving causing the injury. She has been treated with medications and therapy.

Requested Service(s)

Office visits (99211 & 99212), electrical stimulation, ultrasound, neuromuscular re-education, gait training, therapeutic exercises for dates of service 08/06/04 through 09/24/04

Decision

It is determined that there is no medical necessity for the office visits (99211 & 99212), neuromuscular re-education, and gait training for dates of service 08/06/04 through 09/24/04 to treat this patient's medical condition.

It is determined that there is medical necessity for the electrical stimulation and ultrasound for dates of service 08/06/04 through 09/01/04; however, these services are not medically necessary for dates of service 09/02/04 through 09/24/04.

It is determined that there is medical necessity for the therapeutic exercises for dates of service 08/06/04 through 09/01/04 for a maximum of 2 units per visit. On 08/06/04 and 08/16/04, 3 units were performed; only 2 units are medically necessary. Therapeutic exercises for dates of service 09/02/04 through 09/24/04 are not medically necessary.

Rationale/Basis for Decision

The Guidelines of *Chiropractic Quality Assurance and Practice Parameters*¹ Chapter 8 under "Failure to meet Treatment/Care objective" states, "After a maximum of two trial therapy series of manual procedures lasting up to two weeks each (four weeks total) without significant documented improvement, manual procedures may no longer be appropriate and alternative care should be considered". Since the patient failed to significantly improve after the 4-week trial and since the disputed services failed to meet the statutory requirements² for medical necessity, all treatment after 09/01/04 is not medically necessary. Therefore, the electrical stimulation and ultrasound for dates of service 08/06/04 through 09/01/04 is medically necessary; however, these services are not medically necessary for dates of service 09/02/04 through 09/24/04. Additionally, the therapeutic exercises for dates of service 08/06/04 through 09/01/04 are medically necessary; however, only for a maximum of 2 units per visit. The third units on 08/06/04 and 08/16/04 are not medically necessary as well as the therapeutic exercises for dates of service 09/02/04 through 09/24/04 are not medically necessary.

In regard to the gait training service and neuromuscular re-education, there is no medical record documentation to support the need for these services. There is no documentation of a dysfunctional gait and no documentation of neuropathology injury. Therefore, the gait training and neuromuscular re-education is not medically necessary to treat this patient's medical condition.

And finally, the office visits. Medical record documentation does not indicate the need to perform an evaluation and management service on each and every patient encounter especially for a patient in an already-determined treatment plan. Therefore, the office visits (99211 & 99212) for dates of service 08/06/04 through 09/24/04 is not medically necessary to treat this patient's medical condition.

Sincerely,



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

GBS:dm

Attachment

¹ Haldeman, S; Chapman-Smith, D; Petersen, D *Guidelines for Chiropractor Quality Assurance and Practice Parameters*, Aspen Publishers, Inc.

² Texas Labor Code 408.021

Information Submitted to TMF for TWCC Review

Patient Name: ____

TWCC ID #: M5-05-2186-01

Information Submitted by Requestor:

- Requestor's Position
- Progress Notes
- Diagnostic Tests
- Maximum Medical Improvement
- Treatment Notes

Information Submitted by Respondent:

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