

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 Cody B. Doyle, D. C. 1411 N. Valley Mills Ste H Waco, Texas 76710	MDR Tracking No.: M5-05-2329-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Liberty Mutual Insurance Company, 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			
5-5-04	1-13-05	CPT code 99213 from 5-5-04 – 10-15-04, 12-8-04, 1-13-05	X	No
12-28-04	12-28-04	CPT code 99214	X	No
12-28-04	12-28-04	CPT code 99080	X	No
5-5-04	1-13-05	CPT codes 97140, G0283, 97010, 97110, 95831-59, 95851	Yes	X No

PART III: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

In accordance with Rule 133.308 (e), requests for medical dispute resolution are considered timely if they are filed with the division no later than one (1) year after the date(s) of service in dispute. The following date(s) of service are not timely and are not eligible for this review: 4-28-04.

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 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. CPT code 99213 from 5-5-04 through 10-15-04, 12-8-04 and 1-13-05, CPT code 99214 on 12-28-04 and CPT code 99080 on 12-28-04 **were found** to be medically necessary. CPT codes 97010, 97110, 95831-59 and 95851-59 from 5-5-04 through 1-13-05 **were not found** to be medically necessary. The total amount due for the medical necessity issues is \$1,089.47.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 5-28-05 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.

Regarding CPT codes 97140, G0283 and 97010 on 10-15-04: Neither the carrier nor the requestor provided EOB's. The requestor did not submit convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B) or a copy of all medical

bills as originally submitted to the carrier per 133.307 (e)(2)(A). Respondent did not provide EOB's per rule 133.307(e)(3)(B). Recommend no reimbursement.

Regarding CPT code 99080-73: This code was initially denied by the carrier as "V" – unnecessary medical treatment. However, the resubmission EOB shows that the carrier has paid for this service.

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 amount of \$1,089.47, plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

_____	_____	_____
Authorized Signature	Typed Name	6-22-05 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.



Specialty Independent Review Organization, Inc.

June 20, 2005

TWCC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient: _____
TWCC #:
MDR Tracking #: M5-05-2329-01
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to Specialty IRO for independent review in accordance with TWCC Rule 133.308, which allows for medical dispute resolution by an IRO.

Specialty IRO has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Chiropractor. The reviewer is on the TWCC ADL. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

_____ was injured on _____ while lifting a pipe in an oil field. He measures 5'6" and weighs approximately 202 lbs according to the records. The records indicate that he injured his shoulder, neck and lower back. He presented to the company doctor who returned him to work with restrictions. He treated with Drs. Cahill, Lobb, William and Doyle. An MRI was performed on 11/26/03 indicating bulging and protrusion of several cervical levels with neuro-foraminal encroachment. The patient was scheduled for surgery on 1/22/04; however, it was cancelled because the patient ate candy the night before. The records indicate that the carrier disputed the claim on 1/23/04. Several RME's and peer reviews were performed by the carrier doctors. The DD report by Dr. Culver indicates a cervical and lumbar DDD syndrome with cervical and lumbar sprain/strain injuries and aggravation of the pre-existing degenerative disease of both spinal areas. He was assigned a 10% WP IR due to a cervical and lumbar category II DRE rating. The patient's pain scales were rated as a 7/10 on 3/1/04, decreased to a 5/10 on 4/28/04, increased to a 7/10 through 5/12/04, decreased to a 4/10 on 5/19. The same basic pattern remained through December of 2004 when it was rated as a 5/10. As of 1/13/05, the pain scale reduced to a 3/10.

RECORDS REVIEWED

Records were reviewed from both the requestor/treating doctor and the respondent. Records from the requestor/treating doctor include the following: summary of care and explanation of medical necessity letter (undated), multiple records regarding a patient named _____ (unrelated to this case), daily notes by DC Chiropractic Health Services from 1/19/04 through 1/13/05, initial medical report of 11/11/03 and subsequent medical report of 12/28/04.

Records from the respondent include some of the above in addition to the following: Notice of dispute (PLN-11) dated 5/11/05, 1/6/04 report by W. Blair, MD, 2/24/04 DD report by William Culver, MD, 3/22/04 clarification letter by Dr. Culver, 4/4/05 RME report and FCE by Dr. Blair, incomplete TWCC 73 by Dr. Blair dated 9/4/05, 2/10/05 chiropractic modality report by Thomas Sato, DC, 4/25/05 reconsideration letter by Dr. Sato and a handwritten treatment summary (undated).

DISPUTED SERVICES

Disputed services include 97140, G0283, 97010, 99213, 99214, 97110, 99080, 95831-59 and 95851-59 from 5/5/04 through 1/13/05.

DECISION

The reviewer agrees with the previous adverse determination regarding codes 97140, G0283, 97010, 97110, 95831-59 and 95851-59 on all dates of service under review.

The reviewer disagrees with the previous adverse determination regarding the following codes on the following dates: 99213 (5/5/04 through 10/15/04, 12/8/04, 1/13/05), 99214 (12/28/04) and 99080 (12/28/04).

BASIS FOR THE DECISION

The reviewer indicates that the documentation submitted by the requestor does not support the 97110, 95831-59 and 95851-59 codes. There was not a copy of the muscle testing, ROM or therapeutic exercise reports that were performed. Therefore, it is not possible to rate these services as medically necessary. The office visits were approved, as they were well documented and related to the medical management of this patient's injury as per TWCC Guidelines and TLC 408.021. The code 99080 is approved as it was apparently as per 133.106.

REFERENCES

TLC 408.021

TWCC Rule 133.106

ACOEM Guidelines

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that there is no known conflict between the reviewer, Specialty IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,

Wendy Perelli, CEO

CC: Specialty IRO Medical Director