

# 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 clinic C/O Bose Consulting, LLC P O BOX 550496 Houston, Texas 77255	MDR Tracking No.: M5-05-2341-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address  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		
10-04-04	12-10-04	99212, 99213, 97032, 97140, 97035, 97110, 97116, 97112 and E1399	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10-26-04	10-26-04	E1399	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
11-16-04	11-16-04	99080-73	<input checked="" 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. The office visit, electrical stimulation, manual therapy technique, ultrasound, therapeutic exercises, gait training, neuromuscular re-education and durable medical services, rendered on 10-04-04 through 12-10-04 **were not found** to be medically necessary. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 05-31-05, 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.

HCPCS code E1399 on date of service 10-26-04 denied with denial code "N" (not appropriately documented). The requestor did not submit documentation for review. No reimbursement is recommended.

CPT code 99080-73 date of service 11-16-04 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 \$15.00. A Compliance and Practices referral will be made due to the carrier being in violation of Rule 129.5.

**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 the fee service (code 99080-73 date of service 11-16-04) involved in this dispute and is not entitled to reimbursement for the medical necessity issues or a refund of the paid IRO fee. The Division hereby **ORDERS** the insurance carrier to remit the amount of \$15.00 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:

		07-06-05
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.**



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

## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** July 1, 2005

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

**RE: Injured Worker:** \_\_\_\_\_  
**MDR Tracking #:** M5-05-2341-01  
**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:**

- TWCC forms
- Table of disputed services
- Peer reviews
- MRI reports
- NCV reports
- Physical therapy notes
- Daily notes
- Work hardening/conditioning notes
- FCE reports
- Examination reports
- Pain management notes

- SOAP notes
- Exercise sheets

**Submitted by Respondent:**

- 441 pages of material total
- A list of exhibits
- Physician statement
- MRI reports
- FCE reports
- Orthopedic reports
- Various physician reports

**Clinical History**

According to the supplied documentation, it appears that the claimant sustained an injury while at work when she slipped and fell on a wet floor and landed in the corner on one of the sinks. The claimant originally went to the ER, but did not receive any care. The claimant then went to the company physician who performed x-rays and prescribed a course of physical therapy. MRI was performed on 11/5/03 that revealed mild anterior and posterior hypertrophic spondylosis and uncovertebral facet arthropathies bilaterally with desiccation of the entire cervical and upper thoracic spine discs. Lumbar spine x-ray taken on 11/5/03 revealed some disc desiccation at L5-S1 with a grade I anterolisthesis of L5 on S1 with defects of the pars bilaterally. The claimant changed treating doctors to Ramiro Torres, D.C. and began active and passive chiropractic therapy. The claimant underwent extensive chiropractic treatment which was documented in the supplied documentation. On 7/9/04, the claimant underwent an MRA of the head without intravenous contrast which revealed an unremarkable study. The dates of service in question include active and passive chiropractic therapies that were performed from 10/4/04 thru 12/10/04. Some of the documentation goes beyond this date of service, but was not reviewed because of lack of necessity.

**Requested Service(s)**

(99212) office visit, (97032) electrical stimulation, (97140) manual therapy technique, (97035) ultrasound, (97110) therapeutic exercises, (97116) gait training, (97112) neuromuscular re-education, (99213) office visit and (E1399) durable medical for dates of service 10/4/04 to 12/10/04.

**Decision**

I agree with the insurance carrier that the requested services are not medically necessary.

**Rationale/Basis for Decision**

The supplied objective documentation reveals that the claimant sustained an injury to her cervical and lumbar region from an accident that occurred on \_\_\_ while at work. The

compensable injury caused mild disc bulging in the cervical and lumbar regions and potentially aggravated the pre-existing disc desiccation and degeneration that had already occurred in the claimant. The claimant appears to have undergone a full course of physical therapy prior to switching to the chiropractor. The chiropractor reintroduced active and passive modalities and ordered an extensive amount of diagnostic studies as well. A designated doctor report dated 12/31/03 revealed the claimant was not at maximum medical improvement. This report was made by Linda Roos, M.D. Dr. Roos re-examined the claimant on 6/23/04 and determined the claimant was still not at maximum medical improvement. Dr. Roos noted the claimant had extremely mild cervical disc bulges at three levels, an L5-S1 diffuse disc bulge, cervical scapular myofascial pain syndrome, deconditioning and depression. Dr. Roos recommended future treatment. She noted "Of note, the examinee has not made significant progress after seven months of active physical therapy and if more progress is not made soon, consideration should be given towards a home exercise program until the examinee is in a sufficient condition that she is able to progress and prepare for a return to work." Dr. Roos commented that the claimant began therapy shortly after her date of injury of \_\_\_ and therapy had continued continuously through 6/23/04. The dates of service in question began on 10/4/04. This is approximately 18 months after the claimant began therapy. It should be noted that the services performed during October, November and December of 2004 to include manual therapy, muscle stimulation, ultrasound, active therapeutic exercises, stepping as well as office visits. After 18 months, it would appear that this therapy had failed significantly prior to the dates of service in question. Continued and ongoing utilization of the same treatment modalities is not seen as reasonable or medically necessary in the compensable claim. According to the **Official Disability Guidelines**, (page 902) Chiropractic Guidelines; "Include initial trial of 6 visits over 2-3 weeks and with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Avoid chronicity and gradually fade the patient into an active self directed care." This amount of therapy could have been rendered at the initial two months after the claimant had begun chiropractic care. This is in addition to the previous physical therapy that had already been performed. Although the treating physician in this case provided clear and concise documentation, it did not objectively support the rationale for continuing passive and active modalities that had obviously failed for 18 continuous months.

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 1<sup>st</sup> day of July 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder