

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 Integra Specialty Group, P.A. 517 North Carrier Parkway Suite G Grand Prairie, Texas 75050	MDR Tracking No.: M5-05-2397-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Charter Oak Fire Insurance Company Box 05	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		
12-08-04	02-10-05	97012, 97032, 97110, 97140, 99213, 95851 and 95833	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
02-08-05	02-08-05	96004	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
02-10-05	02-10-05	96004	<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** prevail on the **majority** of disputed medical necessity issues. The amount due from the carrier for the medical necessity issues equals **\$2,840.53**.

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 06-23-05, the Medical Review Division submitted a Notice to the 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 date of service 12-23-04 is listed on the table of disputed. Information received from the requestor on 08-18-05 verified that this service had been paid, therefore, will not be a part of the review.

CPT code 99213 dates of service 09-24-04, 10-12-04, 10-15-04, 11-12-04, 11-23-04 and 11-30-04 denied with denial code "Z014" (global). The requestor per Rule 133.304(k)(1)(A) did not submit copies of the medical bills. No determination can be made as to what services were billed for these dates of service and whether or not CPT code 99213 was global. No reimbursement recommended.

CPT code 99080-73 date of service 01-23-05 denied with denial code "V" (unnecessary medical 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 per Rule 133.106(f)(1) in the amount of **\$15.00**

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 a refund of the paid IRO fee in the amount of \$460.00. The Division hereby **ORDERS** the insurance carrier to remit this amount and the appropriate amount for the services in dispute totaling \$2,870.53 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 by:

08-18-05

Authorized Signature

Date of Findings and Decision

Order by:

08-18-05

Authorized Signature

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

If you are unhappy with all or part of this decision, you have the right to appeal the decision. Those who wish to appeal decisions that were issued during the month of August 2005, should be aware of changes to the appeals process which take effect September 1, 2005.

House Bill 7, recently enacted by the 79th Texas Legislature, provides that an appeal of a medical dispute resolution order that is not pending for a hearing at the State Office of Administrative Hearings (SOAH) on or before August 31, 2005 is not entitled to a SOAH hearing. This means that the usual 20-day window to appeal to SOAH, found in Commission Rule 148.3, will be shortened for some parties during this transition phase. If you wish to seek an appeal of this medical dispute resolution order to SOAH, you are encouraged to have your request for a hearing to the Commission as early as possible to allow sufficient time for the Commission to submit your request to SOAH for docketing. A request for a SOAH 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.

Beginning September 1, 2005, appeals of medical dispute resolution orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

Parker Healthcare Management Organization, Inc.

3719 N. Beltline Road, Irving, TX 75038

972.906.0603 972.255.9712 (fax)

Certificate # 5301

August 9, 2005

ATTN: Program Administrator

Texas Workers Compensation Commission

Medical Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100

Austin, TX 78744

Delivered by fax: 512.804.4868

Notice of Determination

MDR TRACKING NUMBER: M5-05-2397-01

RE: Independent review for ____

The independent review for the patient named above has been completed.

- Parker Healthcare Management received notification of independent review on 6.23.05.
- Faxed request for provider records made on 6.24.05.
- TWCC issued an Order for Payment on 7.6.2005.
- The case was assigned to a reviewer on 7.22.05.
- The reviewer rendered a determination on 8.5.05.
- The Notice of Determination was sent on 8.9.05.

The findings of the independent review are as follows:

Questions for Review

The medical necessity of the following services are in question: Mechanical traction (97012), electrical stimulation (97032), therapeutic exercise (97110), manual therapy technique (97140), office visits (99213), ROM (95851), Physician review of motion testing (96004) and muscle test of the whole body (95833). The dates of dispute are 12.8.04 thru 2.10.05.

Determination

PHMO, Inc. has performed an independent review of the proposed care to determine if the adverse determination was appropriate. After review of all medical records received from both parties involved, the PHMO, Inc. physician reviewer has determined to **overturn the denial** of the aforementioned services in dispute, except item listed below.

The PHMO, Inc. physician reviewer has also determined to **uphold the denial** of the Physician review of manual muscle testing (96004.)

Summary of Clinical History

Mr. ____ was injured on the job on ____, while employed with _____. It is documented that he lost his balance while standing on a ladder, pulling boxes that were approximately 120 pounds. He has been having lower back pain that radiates down his left leg from the injury.

Clinical Rationale

Since the time of the accident, the patient has received diagnostic testing such as an MRI, provocative discogram and conservative care consisting of rehabilitation and passive modalities.

He had several disputed visits before 11.19.04, the date of the first set of injections to the psoas muscle. After the injection, the patient had some post injection rehabilitation which is customary and acceptable, and there were only two visits. This was not excessive and not disputed by the carrier. The patient did show clear objective and subjective improvement during this time period.

On 12.29.04, the patient had bilateral L4/5-L5-S1 intra-articular facet injections. Afterwards, the patient received limited post injection rehabilitation, which is supported by medical literature. The rehabilitation consisted of approximately nine therapeutic visits over a two month time period. During this time, the patient improved in every objective category including range of motion and strength.

The patient had an increase in lumbar range of motion that included a 48% increase in left lateral flexion and 20% increase to the right. Lumbar flexion increased 41% and extension 92%. The lumbar strength testing also demonstrated objective improvements. The patient also improved in all subjective categories as well decrease in pain level. The therapy given was standard, not excessive, demonstrated clear relief objectively and subjectively and was documented appropriately.

The Physician Review of Motion Test (96004) is not supported. This code is used in conjunction with other 96000 codes (Regarding Motion Analysis.) Specifically, 96004 calls for "...review and interpretation of comprehensive computer based motion analysis...." The description of Motion Analysis calls for the analysis to be performed in a dedicated motion analysis laboratory (e.g. with 3-D videography.) The provider used a non-laboratory code to describe the work performed.

Clinical Criteria, Utilization Guidelines or other material referenced

- *Occupational Medicine Practice Guidelines*, Second Edition.
- *The Medical Disability Advisor*, Presley Reed MD
- *A Doctors Guide to Record Keeping, Utilization Management and Review*, Gregg Fisher
- *2005 CPT*, pg 306, Standard Edition. American Medical Association.

The reviewer for this case is a doctor of chiropractic peer matched with the provider that rendered the care in dispute. The reviewer is engaged in the practice of chiropractic on a full-time basis.

The review was performed in accordance with Texas Insurance Code §21.58C and the rules of the Texas Workers Compensation Commission. In accordance with the act and the rules, the review is listed on the TWCC's list of approved providers, or has a temporary exemption. The review includes the determination and the clinical rationale to support the determination. Specific utilization review criteria or other treatment guidelines used in this review are referenced.

The reviewer signed a certification attesting that no known conflicts-of-interest exist between the reviewer and any of the providers or other parties associated with this case. The reviewer also attests that the review was performed without any bias for or against the patient, carrier, or other parties associated with this case.

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 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 Tex. Admin. Code § 148.3). This Decision is deemed received by you 5 (five) days after it was mailed and the first working day after the date this Decision was placed in the carrier representative's box (28 Tex. Admin. Code § 102.5 (d)). A request for hearing should be sent to: Chief Clerk of Proceeding/Appeals , 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 this written request for a hearing to the opposing party involved in the dispute.

I hereby verify that a copy of this Findings and Decision was faxed to TWCC, Medical Dispute Resolution department applicable to Commission Rule 102.5 this 9th day of August, 2005. The TWCC Medical Dispute Resolution department will forward the determination to all parties involved in the case including the requestor, respondent and the injured worker. Per Commission Rule 102.5(d), the date received is deemed to be 5 (five) days from the date mailed and the first working day after the date this Decision was placed in the carrier representative's box.

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.

CC: Requestor
Respondent
Patient