

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 Real Health Care 12605 East Freeway Suite 507 Houston, Texas 77015	MDR Tracking No.: M5-05-2398-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address American Casualty Company Box 47	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS 3A080942 K4

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
05-03-04	08-11-04	99214, 99212, 97140, 97035, 97032, 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. Per Rule 133.308(e)(1) date of service 05-03-04 was not timely filed.

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 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 99212 date of service 08-05-04 denied with denial code "R" (extent of injury). On 07-29-03 the carrier accepted the lumbar strain as the compensable injury. The area treated and service billed was for the lumbar area. Reimbursement per Rule 134.202(c)(1) is recommended in the amount of \$48.03 (\$38.42 X 125%).

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 appropriate amount for the services in dispute totaling \$48.03 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:

Authorized Signature

08-12-05

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

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 in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.



PROFESSIONAL ASSOCIATES

NOTICE OF INDEPENDENT REVIEW

NAME OF PATIENT: _____
IRO CASE NUMBER: M5-05-2398-01
NAME OF REQUESTOR: Real Health Care
NAME OF PROVIDER: John T. Randolph, D.C.
REVIEWED BY: Board Certified in Orthopedic Surgery
IRO CERTIFICATION NO: IRO 5288
DATE OF REPORT: 08/05/05

Dear Real Health Care:

Professional Associates has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO) (#IRO5288). Texas Insurance Code Article 21.58C, effective September 1, 1997, allows a patient, in the event of a life-threatening condition or after having completed the utilization review agent's internal process, to appeal an adverse determination by requesting an independent review by an IRO.

In accordance with the requirement for Texas Workers' Compensation Commission (TWCC) to randomly assign cases to IROs, TWCC has assigned your case to Professional Associates for an independent review. The reviewing physician selected has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, the reviewing physician reviewed 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. determination, and any documentation and written information submitted in support of the appeal.

This case was reviewed by a physician reviewer who is Board Certified in the area of Orthopedic Surgery and is currently listed on the TWCC Approved Doctor List.

I am the Secretary and General Counsel of Professional Associates and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or providers or any

of the physicians or providers who reviewed this case for determination prior to referral to the Independent Review Organization.

REVIEWER REPORT

Information Provided for Review:

A progress report dated 05/03/04 from Chris Davis, D.C. at Real Health Care
SOAP notes from Real Health Care dated 05/03/04, 05/06/04, 05/20/04, 05/21/04, 05/24/04, 05/27/04, 06/03/04, 06/04/04, 06/08/04, 06/10/04, 06/11/04, 06/14/04, 06/16/04, 06/17/04, 06/21/04, 06/24/04, 06/28/04, 06/30/04, 07/02/04, 07/07/04, 07/09/04, 07/12/04, 07/14/04, 07/21/04, 07/28/04, 07/30/04, 08/05/04, and 08/11/04
An evaluation with Barry Nelms, M.D. on 05/14/04
A progress report from Dr. Davis dated 06/03/04
A follow-up evaluation dated 07/07/04 from Dr. Davis
A progress report from John T. Randolph, D.C. dated 08/11/04

Clinical History Summarized:

On 05/03/04, Dr. Davis recommended therapy three to four times a week for four to six weeks. From 05/03/04 through 08/11/04, the claimant attended therapy at Real Health Care. On 05/14/04, Dr. Nelms noted the claimant had undergone a laminectomy at L4-L5 and L5-S1 with discectomy (the operative report was unavailable for my review). Dr. Davis recommended continued therapy two to three times a week for four to six weeks on 07/07/04. On 08/11/04, Dr. Randolph noted the claimant had lower back pain with radiation into her left leg. He recommended the claimant return to Dr. Nelms and noted she might be a candidate for further surgery.

Disputed Services:

Office visits, manual therapy technique, ultrasound, electrical stimulation, and therapeutic exercises from 05/03/04 through 08/11/04

Decision:

I agree with the insurance company as the office visits, manual therapy technique, ultrasound, electrical stimulation, and therapeutic exercises from 05/03/04 through 08/11/04 do not appear reasonable or necessary.

Rationale/Basis for Decision:

The claimant's injury was in _____. The claimant was treated in the past with surgical intervention, which was complicated by dural leaks. Thereafter, the claimant was treated with medications. The claimant had completed a pain management program. Utilizing either The Occupational Medicine Practice Guidelines or the North American Spine Society Guidelines, there was no place for the type of therapy that was rendered from 05/03/04 through 08/11/04. The claimant had already completed a tertiary pain management program and, therefore, should be independent in an home based exercise program. The passive therapies rendered have never been shown experimentally to change the progress of the complaints that the claimant exhibited. Therefore, there was no necessity for the manual therapy, ultrasound, electrical stimulation, or therapeutic exercises from 05/03/04 through 08/11/04.

This review was conducted on the basis of medical and administrative records provided with the assumption that the material is true and correct.

This decision by the reviewing physician consulting for Professional Associates is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this 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 twenty (20) calendar days** of your receipt of this decision (28 Texas Administrative Code 148.3).

This decision is deemed received by you **five (5) calendar days** after it was mailed and the first working day after the date this decision was placed in the carrier representative's box (28 Texas Administrative Code 102.5 (d)). A request for a hearing should be faxed to 512-804-4011 or sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P. O. Box 17787
Austin, TX 78744

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization's decision was sent to TWCC via facsimile or U.S. Postal Service on 08/05/05 from the office of Professional Associates.

Sincerely,

Amanda Grimes
Secretary/General Counsel