

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 SCD Back and Joint Clinic, Ltd. 200 E 24 th Street, Suite B Bryan, Texas 77803	MDR Tracking No.: M5-05-2420-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Liberty Mutual Fire Insurance 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		
07-02-04	10-13-04	97110, 97112, 97530, 98940, 98943, 97124, 99213, 99211, 99212, 95851, 97018, 97012, 97024 and 97150	<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** prevail on the disputed medical necessity issues. The amount due from the carrier for the medical necessity issues equals **\$4,113.82**.

On 07-06-05 the requestor withdrew the fee issues within this dispute.

CPT codes 97139-EU and 97750-MT listed on the table of disputed services were billed with invalid modifiers and will not be part of the review. Per Rule 134.202(b) "...system participants shall apply the Medicare program reimbursement methodologies, models and values or weights including its coding, billing, and reporting payment...". The provider will be billed due to billing with modifiers that after 08-01-03 were invalid.

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 99080-73 date of service 09-07-04 denied with denial code "U" (unnecessary medical treatment without 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. 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 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 \$4,128.82 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:

08-17-05

Authorized Signature

Date of Findings and Decision

Order by:

08-17-05

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: M5-05-2420-01

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 Records from the respondent on 7.6.05.
- The case was assigned to a reviewer on 7.18.05.
- The reviewer rendered a determination on 8.4.05.
- The Notice of Determination was sent on 8.9.05.

There are 3 pages included in this determination. The findings of the independent review are as follows:

Questions for Review

The therapy in question are listed as Therapeutic exercise (97110), Neuromuscular re-education (97112), Therapeutic activities (97530), chiropractic manipulative therapy (98940/98943), massage therapy (97124), office visits (99213/99211/99212), Range of motion (95851), paraffin bath (97018), mechanical traction (97012), diathermy (97024 and group procedures (97150). All of the aforementioned therapy is denied with a "U and V" code. These are related to fee and medical necessity issues. The dates in question are listed as 7.2.04 thru 10.13.04.

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** on all the aforementioned services.

Summary of Clinical History

Ms. ____ sustained a work related job injury on ____, while employed with ____ .. She claimed pain in the neck, shoulders, upper and mid back, right elbow and the right arm. There is documentation that outlines that she was having some numbness and tingling from the neck into the upper extremities including both of the arms and the hands. The injury is reported to have occurred as a result of repetitive usage of the upper extremities.

Clinical Rationale

The patient had significant increases in strength (statically) during the time period in question. It improved between 17.4% and 183.5 % in various lifting exercises over two months. Range of motion increased significantly over the course of two months. Between the dates of 7.5.04 and 9.2.05, the patient's ROM improved between 8.6% and 43.9%, depending on the motion tested. The patient regressed in only one motion, for a very marginal 1.6% loss.

The improvement was obvious. The upper extremity strength improvement, during this time period, was also obvious and ranged from 13.6 % to 665.5%. Beyond the date of 9.2.04, the patient continued to show very clear objective improvement. The injury was documented in various areas via advanced imaging and the treatment and therapy was clearly and appropriately documented. As a result, the therapy in question was clearly beneficial to the patient.

There was a peer review done by a Glenn Marr, D.C. that was severely deficient, lacked content and made a vague, broad denial of care based upon "standards of care." The reviewing provider may have overlooked the vast amount of objective improvement, which is meticulously detailed in the provider's records. This review carries no credibility in regards to necessity of care.

On the 9.10.04 medical examination that was performed by a Hugh Ratliff, M.D., he recommended over the counter analgesics as well as further chiropractic care. He recommended MRI's and upper extremity electrodiagnostic studies. He listed the conservative chiropractic treatments that were to be continued that included chiropractic treatment, ultrasound and passive modalities, stretching and massage as well as immobilization splints. He felt the injuries were related to her job accident and MMI had not been reached.

A case review done by a Robert Francis D.C. on March 22, 2005, also supported care that had been rendered and stated that the length and frequency of care has been appropriate and medical necessary.

The conclusion is that the care administered during 7.2.04 thru 10.13.04 is overwhelming in regards to favorable outcome assessment. The care clearly created a curative effect and alleviated symptoms. This care was medically appropriate.

Clinical Criteria, Utilization Guidelines or other material referenced

- *Occupational Medicine Practice Guidelines*, Second Edition.
- *The Medical Disability Advisor*, Presley Reed MD

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