

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 Philip R. Estrada, D. C. 9521-C West FM 1097 Willis, TX 77318	MDR Tracking No.: M5-05-2431-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address American Home Assurance, Box 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS - MEDICAL NECESSITY ISSUES

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
5-17-04	10-13-04	CPT codes 97110, 97124, 97140, G0283, 97022, 98940, 99212, 99213, 99215 and 95851	<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.

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: 4-19-04 through 5-12-04.

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

On 6-24-05 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 95851-25 on 5-12-04 and 6-14-04 was denied as "435-The value of this procedure is included in the value of the comprehensive procedure." Per the 2002 MFG "25" is not a valid modifier. **Recommend no reimbursement.**

CPT code 97110 for 9-13-04, 9-15-04, 9-17-04, and 9-27-04 were denied as "713 - The charge exceeds the values and/or parameters that would appear reasonable." Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the

medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. **Reimbursement not recommended.**

CPT code 97124 on 9-15-04, 9-17-04 and 9-27-04 were denied as "713 – The charge exceeds the values and/or parameters that would appear reasonable." The medical necessity of services for an unusual length of time was documented by the requestor. Reimbursement will be according to Rule 134.202. **Recommend reimbursement of \$78.84 (\$26.28 X 3 DOS).**

CPT code 97750-25 on 8-3-04 and 6-14-04 was denied as "973 – payment denied as the modifier is incorrect or no longer valid." Per the 2002 MFG "25" is no longer valid for this service. **Reimbursement not recommended.**

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 consistent with the applicable fee guidelines totaling \$78.84 for 9-15-04, 9-17-04 and 9-27-04, 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:

7-26-05

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



Specialty Independent Review Organization, Inc.

July 18, 2005

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

Patient: ____
TWCC #: ____
MDR Tracking #: M5-05-2431-01
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

This patient was injured on the job on ____ with ____ when she was working as a night stocker and was lifting boxes which contained car jacks from a pallet and had an immediate onset of severe low back pain with bilateral radiculopathy symptoms. She initially went to Huntsville Memorial Hospital and was prescribed X-rays. She then sought treatment from the Advanced Ortho Rehab clinic. She was eventually diagnosed with a herniated disc at L5/S1 and underwent surgery for this condition on February 3, 2005. Records indicate there were 112 physical medicine visits for this patient and there had not been a work hardening program or chronic pain program. She had previously undergone ESI therapy in May, June and August of 2004. She also had an intradiscal injection February 3, 2005, apparently during the surgery.

RECORDS REVIEWED

From the Requestor-TWCC-60/with tables, EOB's, HCFA 1500, office notes of Advanced Ortho Rehab, PA, treating clinic evaluation narratives, PT notes, J-Tech PPE findings.

From the Respondent:-History of treatments, peer reviews from ConsiliumMD by Michael Hamby, DC, Brad Hayes, DC, Bobby Enkvetchakul, MD and Phillip Osborne, MD; hospital records from Huntsville Memorial; office notes of Advanced Ortho Rehab, treating clinic evaluations and narratives, PT notes, J-Tech PPE findings; narrative of Texas Pain Institute, Dr. Son Nguyen; electrodiagnostic studies by Gregory Mrozinski, DC; TWCC 73's; Operative report of Son Nguyen, MD (ESI/epidurogram); evaluation by William Donovan, MD; report by Don Mackey, MD

DISPUTED SERVICES

Disputed services include the following: 97110, 97124, 97140-59, G0283, 97022, 98940-51, 99212-25, 99213-25, 99214-25 and 95851 from 5/17/04 through 10/13/04.

DECISION

The reviewer agrees with the previous adverse determination.

BASIS FOR THE DECISION

The reviewer found no documentation of any form of progress on this case that would indicate 114 office visits to be rendered prior to surgery. While it is certainly reasonable to help a patient recover from a surgical procedure, the treatment rendered here was prior to the surgical procedure being performed. It had become clear by the beginning of the dispute date that there was no method of manipulation or physical medicine that would get this patient back to work in a reasonable manner and indeed that the patient was not progressing with any significance at any point during the treatment plan. Certainly, post surgical treatment is not affected by this review, only that which was performed prior to the surgery. No treatment guideline found by the reviewer, including the Texas Guidelines to Quality Assurance, would justify such extensive treatment prior to surgery being instituted, especially considering that the treatment was clearly rendering no positive results by the documentation presented. As a result, there is not found to be any medical necessity for the treatment rendered on this case.

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