

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 Dr. Marsha Miller 2306 S. Buckner Dallas, TX 75227	MDR Tracking No.: M5-05-2435-01
	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 – MEDICAL NECESSITY ITEMS

<u>Dates of Service</u>		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
10-19-04	2-2-05	CPT codes 97110, 98940, 97140, G0283, 97012, 97022, 99211, 99213	<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 **prevailed** on the disputed medical necessity issues. The amount due the requestor for the medical necessity issues is \$1,072.89.

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 6-23-05 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.

Regarding CPT code 99358-52: Per Rules 134.202(b) and 134.202(e)(9) this is an inappropriate use of modifiers. Per the 2002 MFG "52" is not a valid modifier for this CPT code. This service will not be a part of this review.

Regarding CPT code G0283 on 11-11-04 and 12-14-04: The carrier utilized the wrong CPT code on the EOB's. Recommend reimbursement of \$28.82 (\$14.41 X 2 DOS).

Regarding CPT code 99080-73 on 12-17-04: The carrier indicated that the requestor had been reimbursed for this service. However, the requestor states that it has received no payment. Recommend reimbursement of \$15.00.

PART IV: COMMISSION DECISION AND ORDER

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 the amount of \$1,116.71, plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Donna Auby

7-29-05

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

July 28, 2005

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-05-2435-01
TWCC#: _____
Injured Employee: _____
DOI: _____
SS#: _____
IRO Certificate No.: IRO 5055

Dear Ms. ____:

IRI has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc. and I certify that the reviewing healthcare professional 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 other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is licensed in chiropractic care, and is currently on the TWCC Approved Doctor List.

Sincerely,

Gilbert Prud'homme
General Counsel

GP:dd

REVIEWER'S REPORT
M5-05-2435-01

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor:

Correspondence

Office Notes 08/24/04 – 04/18/05

Physical Therapy Notes 11/02/04 – 01/18/05

Functional Capacity Eval 08/16/04

Nerve Conduction Study 08/04/04 – 03/28/05

Radiology Report 05/10/04 – 01/07/05

Information provided by Respondent:

Correspondence

Designated Review

Spine:

Office Notes 08/27/04 – 06/10/05

Neuro-Surgery:

Office Visit 04/12/05

Clinical History:

Patient is a 29-year-old male laborer who, on ____, injured his lower back and right shoulder. Reportedly on that date, he was standing approximately 6 feet above the ground on a wet trailer attempting to pull down the overhead door when he slipped and fell, landing onto his buttocks and right shoulder. He was initially seen at the emergency room, and then followed-up with an orthopedist who recommended physical therapy. After 4 months, he changed treating doctors to a doctor of chiropractic who performed manipulation, physical therapy and rehabilitation. When the patient's response was limited, he was referred for a trial of epidural steroid block injections to his lower back, as well as subacromial injections to his right shoulder, both followed by post-injection physical therapy and rehabilitation. Despite the conservative trial, however, the patient eventually underwent anterior to posterior discectomy and interbody fusion at L4-5 and L5-S1 on 6/1/05.

Disputed Services:

Therapeutic exercises, chiropractic manipulation, manual therapy technique, electrical stimulation, mechanical traction, whirlpool and office visits.

Decision:

The reviewer disagree with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were medically necessary in this case.

Rationale:

In this case, the records adequately documented that a compensable injury occurred to the lower back and right shoulder, and that both areas required treatment. In addition, the “chiropractic daily notes” accurately demonstrated that the care provided relieved the patient’s symptoms, as the “pre-” and “post-pain levels” repeatedly decreased as a result of the treatment rendered.

Therefore, the care rendered met the statutory requirements¹ since it was adequately documented that the patient obtained relief from the care provided.

It is also important to note that although the dates in dispute were several months post-injury, the records reflected that the treatments rendered were according to a post-injection protocol, and that the modalities and procedures utilized were in accordance with the performing surgeon’s recommendations. And, it was reasonable to attempt an injection protocol before resorting to surgical intervention. Therefore, the care provided in this case was supported as medically necessary.

¹ Texas Labor Code 408.021