

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 South Coast Spine and Rehabilitation, P.A. 602 Paredes Line road Brownsville, Texas 78521 | MDR Tracking No.: M5-05-2462-01 |
| | TWCC No.: |
| | Injured Employee's Name: |
| Respondent's Name and Address Risk Management Fund Box 12 | 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 | | |
| 10-22-04 | 12-16-04 | 99213-25 | <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.

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 reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

Authorized Signature

07-08-05

Date of Decision

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.

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

Phone: 512-402-1400

FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

| | |
|--|------------------------------------|
| TWCC Case Number: | |
| MDR Tracking Number: | M5-05-2462-01 |
| Name of Patient: _____ | |
| Name of URA/Payer: | South Coast Spine & Rehabilitation |
| Name of Provider: (ER, Hospital, or Other Facility) | South Coast Spine & Rehabilitation |
| Name of Physician: (Treating or Requesting) | Robert S. Howell, DC |

July 5, 2005

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Texas Workers Compensation Commission

CLINICAL HISTORY

Documents Reviewed Included the Following:

1. Treatment notes from provider
2. FCEs
3. EOBs
4. Report of Oliver Achleitner, M.D.
5. Carrier correspondence

61-year-old Hispanic male underwent physical medicine treatments and FCEs after falling at work on ____.

REQUESTED SERVICE(S)

(99213) office visits from 10/22/04 to 12/16/04.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

In general, most computerized documentation, regardless of the software used, fails to provide individualized information necessary for reimbursement. The Center for Medicare and Medicaid Services (CMS)

has stated, "Documentation should detail the specific elements of the chiropractic service for this particular patient on this day of service. It should be clear from the documentation why the service was necessary that day. Services supported by repetitive entries lacking encounter specific information will be denied." In this case, there is insufficient documentation to support the medical necessity for the disputed treatment in question since the computer-generated daily progress notes were essentially identical for each date of service.

More importantly and based on CPT ¹, there is no support for the medical necessity for the high level of E/M service (99213) on each and every visit during an established treatment plan.

¹ *CPT 2004: Physician's Current Procedural Terminology, Fourth Edition, Revised.* (American Medical Association, Chicago, IL 1999),