THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-05-9128.M5

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 Gabriel Gutierrez, D.C. P O BOX 229 Katy, Texas 77492-0229	MDR Tracking No.: M5-05-2488-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Atlantic Mutual Insurance Company Box 19	Date of Injury: Employer's Name: Insurance Carrier's No.: 21921373

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	**To**		
07-19-04	**09-13-04**	**90801, 97545 and 97546**	☐ **Yes** ☒ **No**
			☐ **Yes** ☐ **No**
			☐ **Yes** ☐ **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.

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 06-29-2005, 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 codes 97545-WH-CA and 97546-WH-CA dates of service 08-27-04 through 09-13-04 (10 DOS) denied with denial code "A" (preauthorization required but not requested). The requestor is a CARF provider, therefore, preauthorization is not required. Reimbursement is recommended as follows:

97545-WH-CA $1,280.00 ($64.00 X 20 units billed)
97546-WH-CA $2,240.00 ($64.00 X 35 units billed)

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 reimbursement for the fee services totaling $3,520.00 involved in this dispute and 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, 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:

		07-19-05
Authorized Signature		Date of Decision
Order By:		
		07-19-05
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

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:	M5-05-2488-01
Name of Patient:	___
Name of URA/Payer:	Gabriel Gutierrez, DC
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Todd L. Bear, DC

July 13, 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. Correspondence, examination and treatment records from the provider
2. Designated doctor examination
3. Correspondence from the carrier's attorney
4. FCE
5. Psychological evaluations
6. Vocational assessment report
7. CARF certification

Claimant underwent ER care, physical medicine treatments and examinations after tripping over a runner and falling at work on ___.

REQUESTED SERVICE(S)

Work hardening program 97545-WH-CA, 97546-WH-CA and the psychiatric diagnostic interview exam from 07/19/04 to 09/13/04.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

In the preamble of the Texas Workers Compensation Commission's amendments to rule 134.600, the Commission states as follows: "Over-utilization of medical care can both endanger the health of injured workers and unnecessarily inflate system costs. Unnecessary and inappropriate health care does not benefit the injured employee or the workers' compensation system. Unnecessary treatment may place the injured worker at medical risk, cause loss of income, and may lead to a disability mindset. Unnecessary or inappropriate treatment can cause an acute or chronic condition to develop." [1] In its report to the legislature, the Research and Oversight Council on Texas Workers'

[1] 26 Tex. Reg. 9874 (2001)

Compensation explained its higher costs compared to other health care delivery systems by stating, "Additional differences between Texas workers' compensation and Texas group health systems also widen the cost gap. These differences include…in the case of workers' compensation, the inclusion of costly and questionable medical services (e.g., work hardening/conditioning.)" [2]

In this case, the provider's work hardening program was just the type of questionable services of which the TWCC and the legislature spoke when expressing concern in regard to medically unnecessary treatments that may place the injured worker at medical risk, create disability mindset, and unnecessarily inflate system costs.

The records fail to substantiate that the aforementioned services fulfilled the statutory requirements [3] for medical necessity since there is no documentation that the claimant obtained relief, that promotion of recovery was accomplished or that the treatment enhanced the employee's ability to return to employment.

Specifically, the patient's pain rating was 40/100 (as stated in the records) on 07/15/04 at the initiation of the disputed treatment and was 3-5/10 when last recorded on 08/27/04 near the end of the disputed treatment.

Moreover, the patient presented with the exact same and verbatim symptoms on each and every visit during the disputed time frame. In regard to promoting recovery, no re-examination was performed after the treatment so there is no way to determine if the care had any beneficial effect.

The medical records also do not substantiate that the treatment enhanced the claimant's ability to return to work. That is especially important in this case since the designated doctor (who carries presumptive weight) determined the claimant to be MMI on 01/08/04 – a full six months before the initiation of the disputed treatment – with a 0% impairment.

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[2] "Striking the Balance: An Analysis of the Cost and Quality of Medical Care in Texas Workers' Compensation System," Research and Oversight Council on Workers' Compensation, Report to the 77th Legislature, page 6.
[3] Texas Labor Code 408.021

And finally, current medical literature states, "…there is no strong evidence for the effectiveness of supervised training as compared to home exercises. There is also no strong evidence for the effectiveness of multidisciplinary rehabilitation as compared to usual care." [4] The literature further states "…that there appears to be little scientific evidence for the effectiveness of multidisciplinary biopsychosocial rehabilitation compared with other rehabilitation facilities…" [5] And a systematic review of the literature for a multidisciplinary approach to chronic pain found only 2 controlled trials of approximately 100 patients with no difference found at 12-month and 24-month follow-up when multidisciplinary team approach was compared with traditional care.[6] Based on those studies, the medical necessity of the disputed treatment is without support.

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[4] Ostelo RW, de Vet HC, Waddell G, Kerchhoffs MR, Leffers P, van Tulder M, Rehabilitation following first-time lumbar disc surgery: a systematic review within the framework of the cochrane collaboration. Spine. 2003 Feb 1;28(3):209-18.

[5] Karjalainen K, Malmivaara A, van Tulder M, Roine R, Jauhiainen M, Hurri H, Koes B. Multidisciplinary biopsychosocial rehabilitation for neck and shoulder pain among working age adults. Cochrane Database Syst Rev. 2003;(2):CD002194.

[6] Karjalainen K, et al. Multidisciplinary rehabilitation for fibromyalgia and musculoskeletal pain in working age adults. Cochrane Database of Systematic Reviews 2000;2.