

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 Horizon Health c/o Bose Consulting, LLC P O BOX 550496 Houston, Texas 77255	MDR Tracking No.: M5-05-2516-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Federal Insurance Company Box 17	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		
01-03-05	02-18-05	99212, 99213 and 97110	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
01-03-05	02-18-05	97112 and 97140	<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** prevail on the **majority** of disputed medical necessity issues. The amount of reimbursement due from the carrier for the medical necessity issues equals **\$4,988.97**.

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 08-12-05, 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 01-17-05 denied with denial code "V" (unnecessary medical treatment with 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 in this matter. Reimbursement is recommended in the amount of **\$15.00**.

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 \$5,003.97 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:

08-30-05

Authorized Signature

Medical Dispute Officer

Date of Findings and Decision

Order by:

08-30-05

Authorized Signature

Associate Director
Medical Review Division

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 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:	M5-05-2516-01
Name of Patient:	_____
Name of URA/Payer:	Horizon Health c/o Bose Consulting
Name of Provider: (ER, Hospital, or Other Facility)	Horizon Health
Name of Physician: (Treating or Requesting)	Carrie Schwartz, DC

August 8, 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

Available information suggests that this patient reports a work related injury to his ankle and lower back on _____. He presented initially to the ER at Memorial Southeast Hospital in Houston and received x-rays and medications. MRIs from 08/05/04 suggest mild strain of the ant. talofibular ligament and disc bulging of the L4/5 and L5/S1 discs. The patient appears to begin treatment with a chiropractor, Dr. Carrie Schwartz, and undergoes multiple sessions of both active and passive physical therapy. On 09/24/04 the patient is referred for orthopedic assessment with a Dr. Jeffery Reuben where recommendations for epidural steroid injections are made. On 10/20/04 the patient is seen for ESIs with a pain management specialist, Dr. Ben Tiongson. The patient is seen for designated doctor evaluation on 12/01/04 by a Dr. Raul Zayas and is found not to be at MMI. The patient is seen for a neurosurgical assessment on 12/07/04 and is directed to continue with conservative treatment. Follow-up assessment with Dr. Tiongson on 01/31/05 suggests that

the patient continue with active therapy and injections. Chiropractic notes from Dr. Schwartz, treating chiropractor, from 01/03/05 to 02/18/05 suggest that the patient continues with multiple passive modalities including hot/cold packs, EMS, joint mobilization, myofascial release, massage in addition to exercise and unspecified neuromuscular reeducation.

REQUESTED SERVICE(S)

Determine medical necessity for office visits (99212, 99213), therapeutic exercise (97110), neuromuscular reeducation (97112) and manual therapy technique (97140) for period in dispute 01/03/05 through 02/18/05.

DECISION

Approve 99212, 99213 (office visits) and 97110 (therapeutic exercise).

All other services denied.

RATIONALE/BASIS FOR DECISION

Medical necessity for ongoing passive therapy (01/02/05 through 02/18/05) is **not supported** by available documentation, specifically 97112 & 97140 modalities. Ongoing therapeutic applications of this nature suggest little potential for further restoration of function or resolution of symptoms at 5-6 months post injury. Though neuromuscular reeducation is not necessarily a purely passive activity, treating chiropractor does not indicate what this therapy involves, how it is applied, and for what specific goal or purpose it is used. E&M services 99212 and 99213 do appear reasonable as applied, as does therapeutic exercise 97110.

1. Philadelphia Panel Evidence-Based Clinical Practice Guidelines on Selected Rehabilitation Physical Therapy, Volume 81, Number 10, October 2001.
2. Hurwitz EL, et al. The effectiveness of physical modalities among patients with low back pain randomized to chiropractic care: Findings from the UCLA Low Back Pain Study. *J Manipulative Physiol Ther* 2002; 25(1):10-20.
3. Bigos S., et. al., AHCPR, Clinical Practice Guideline, Publication No. 95-0643, Public Health Service, December 1994.
4. Harris GR, Susman JL: "Managing musculoskeletal complaints with rehabilitation therapy" Journal of Family Practice, Dec, 2002.
5. Morton JE. Manipulation in the treatment of acute low back pain. *J Man Manip Ther* 1999; 7(4):182-189.
6. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Mercy Center Consensus Conference, Aspen Publishers, 1993.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials.

No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned individual. These opinions rendered do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.