

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 Benjamin Barnette, D.C. 3107 Center Pointe Drive Edinburg, Texas 78539	MDR Tracking No.: M5-05-2542-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Box 29	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		
11-19-04	01-18-05	98940, G0283, 97110, 97112 and 97124 (denied for medical necessity)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
01-19-05	02-10-05	98940, G0283, 97124, 97110 and 97112 (denied for medical necessity)	<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 **\$1,112.15**.

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 07-06-05, 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 99083 dates of service 11-19-04, 12-17-04, 01-05-05, 01-19-05, 01-24-05 and 02-10-05 is listed on the table of disputed services. Per the 2002 Medical Fee Guideline this is an invalid code and will not be part of the review.

CPT codes 97035, G0283, 97012, 97124, 98940, 97112 and 95831 billed on dates of service 11-19-04, 11-22-04, 11-23-04, 11-29-04, 11-30-04, 12-14-04, 12-15-04 and 12-20-04 denied with denial code "N" (there is no explanation of mechanical traction or E-stim. A generic description of CPT codes does not document what activities were performed or for how long. Documentation does not support all billed time units of exercise or therapy. Flowsheet not provided. The requestor did not submit documentation for review. No reimbursement is recommended.

Review of CPT codes 98940, G0283, 97012, 97035, 97124, 97110 and 97112 dates of service 12-02-04, 12-06-04, 12-07-04, 12-08-04, 12-13-04, 12-14-04, 12-20-04, 12-22-04, 01-17-05, 01-18-05 and 01-19-05 revealed that neither party submitted a copy of EOBs. Per Rule 133.307(e)(2)(B) there is no convincing evidence of carrier receipt of the providers request for EOBs. No reimbursement is recommended.

CPT code G0283 dates of service 11-19-04 and 12-10-04 denied with denial code "D". Since neither party submitted an original EOB the review will be per Rule 134.202. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$26.82 (\$10.73 X 125% = \$13.41 X 2 DOS)**.

CPT code 97012 dates of service 11-19-04 and 12-10-04 denied with denial code "D". Since neither party submitted an original EOB the review will be per Rule 134.202. Reimbursement per Rule 134.202(c)(1) is \$17.91 (\$14.33 X 125%). The requestor billed \$17.76 for each date of service. Reimbursement is recommended in the amount of **\$35.52**.

CPT code 98940 date of service 12-10-04 denied with denial code "D". Since neither party submitted an original EOB the review will be per Rule 134.202. Reimbursement per Rule 134.202(c)(1) is recommended in the amount of **\$31.35 (\$25.08 X 125%)**.

CPT code 97035 date of service 12-10-04 denied with denial code "D". Since neither party submitted an original EOB the review will be per Rule 134.202. Reimbursement per Rule 134.202(c)(1) is \$14.81 (\$11.85 X 125%). The requestor billed \$14.63. Reimbursement is recommended in the billed amount of **\$14.63**.

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 \$1,220.47 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 and Order by:

Authorized Signature

08-12-05

Date of Decision and 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.



7600 Chevy Chase, Suite 400
Austin, Texas 78752
Phone: (512) 371-8100
Fax: (800) 580-3123

NOTICE OF INDEPENDENT REVIEW DECISION

Date: August 8, 2005

To The Attention Of: TWCC
7551 Metro Center Drive, Suite 100, MS-48
Austin, TX 78744-1609

RE: Injured Worker: _____
MDR Tracking #: M5-05-2542-01
IRO Certificate #: IRO 5263

Forté has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractic reviewer who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- Statement letter
- MRI reports
- Doctor evaluation notes
- TWCC forms
- Massage therapy notes
- Exercise notes
- Examination reports

Submitted by Respondent:

- TWCC forms
- Benefit dispute agreement
- RME reports
- MMI reports
- Daily notes

- Weekly evaluation reports
- Peer reviews
- Exercise notes

Clinical History

According to the supplied documentation, the claimant sustained an injury on ___ when he was involved in a motor vehicle accident. The claimant was driving a bus, while in the normal scope and practice of his employment. The claimant reported injuries to his neck, low back and left knee. The claimant was seen on 11/18/04 with Benjamin Barnett, D.C. Dr. Barnett diagnosed the claimant with a cervical sprain/strain, a lumbar sprain/strain and a knee contusion. The claimant was returned to work with no restrictions. The claimant began passive chiropractic modalities. The claimant underwent a lumbar MRI on 12/13/04. A 2mm central bulge of the disc at L1/2, L2/3, L3/4 and L4/5 was seen. At L5/S1, there was a 4mm central to right central disc protrusion. Multiple levels of discs were dehydrated. On 1/13/05 the claimant was seen by Jorge E. Tijmes, M.D. for an orthopedic consult. Dr. Tijmes diagnosed the claimant with low back pain, neck pain and left knee sprain. He reported the claimant was not a surgical candidate to the knee, but would benefit from an EMG/NCV study of the lower extremities. The claimant was prescribed medications. The claimant was seen by Rueben D. Pechero, M.D. on 1/27/05 for an evaluation. Dr. Pechero reported that he strongly felt the claimant was not a surgical candidate, but could be a candidate for epidural steroid injections. The documentation ends here.

Requested Service(s)

Chiropractic manipulative treatment – 98940, electrical stimulation (unattended) – G0283, therapeutic exercises – 97110, neuromuscular re-education – 97112, and massage therapy – 97124 for dates of service 11/19/04 through 2/10/05

Decision

I disagree with the carrier and find that the services rendered between 11/19/04 through 1/18/05 were medically necessary. I agree with the carrier and find that the services rendered from 1/19/05 through 2/10/05 were not medically necessary.

Rationale/Basis for Decision

According to the supplied documentation, the claimant sustained an injury on ___. The documentation supplied objectively supports that the claimant had some pre-existing conditions associated with the disc dehydration and disc bulges in his lumbar spine. The compensable injury is deemed as a sprain/strain to the lumbar spine. Current medical protocols support approximately 2 months of active and passive therapies following these types of injuries. After review of the services in dispute, the first 2 months of care is seen as reasonable and medically necessary beginning on 11/18/04 through 1/18/05. At that time, it would be reasonable and medically necessary to refer the claimant, which was done to 2 separate medical doctors. Care rendered after 1/19/05 was not objectively supported by the documentation and was not seen as necessary in the treatment of the compensable work injury.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 8th day of August 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder