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

SOAH DOCKET NO. 453-05-9151.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 Carl M. Naehritz, III, D.C. 2900 Highway 121 Suite 120 Bedford, Texas 76053	MDR Tracking No.: M5-05-2544-01 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

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	**To**		
09-27-04	**09-27-04**	**99372**	☒ **Yes** ☐ **No**
08-16-04	**09-27-04**	**99213, 97530, 97112 and 97140**	☐ **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 **majority of** disputed medical necessity issues. The amount of reimbursement due from the carrier for the medical necessity issues equals $42.50.

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 06-22-2005, 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 code 97750-FC dates of service 06-15-04 and 01-24-05 denied with denial code "F" (Fee Guideline reduction). The carrier has not made a payment. Reimbursement of **$200.00** is recommended per the 2002 Medical Fee Guideline.

CPT code 97750-FC date of service 01-24-05 denied with denial code "F" (Fee Guideline reduction). The carrier has made a payment of $192.62. Additional reimbursement is recommended in the amount of **$7.38** per the 2002 Medical Fee Guideline.

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 services involved in this dispute totaling $249.88 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 and Order by:

Authorized Signature		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.

Parker Healthcare Management Organization, Inc.
3719 N. Beltline Road, Irving, TX 75038
972.906.0603 972.255.9712 (fax)
Certificate # 5301

July 22, 2005

ATTN: Program Administrator
Texas Workers Compensation Commission
Medical Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100
Austin, TX 78744
Delivered by fax: 512.804.4868

Notice of Determination

MDR TRACKING NUMBER: M5-05-2544-01
RE: Independent review for ___

The independent review for the patient named above has been completed.

- Parker Healthcare Management received notification of independent review on 6.21.05.
- Faxed request for provider records made on 6.21.05.
- The case was assigned to a reviewer on 7.5.05.
- The reviewer rendered a determination on 7.19.05.
- The Notice of Determination was sent on 7.22.05.

The findings of the independent review are as follows:

Questions for Review

The therapy in question consists of office visits (99213), therapeutic activities (97530), neuromuscular re-education (97112), manual therapy technique (97140) and telephone call (99372). The dates of service in question are the dates of 8.16.04 through the dates of 9.27.04.

Determination

PHMO, Inc. has performed an independent review of the proposed care to determine if the adverse determination was appropriate. After review of all medical records received from both parties involved, the PHMO, Inc. physician reviewer has determined to **overturn the denial** of the disputed phone call (99372.)

The PHMO, Inc. reviewer has determined to **uphold the denial** of all remaining claims.

Summary of Clinical History

Mr. ___ sustained a work related job injury ___, while employed with .

Clinical Rationale

The patient was injured ___, revealing that the therapy in question took place approximately 1 year following this event. The objective findings reveal that between the dates of 1.24.04 and 2.26.05, the patient's condition regressed. In particular, the FCE dated 1.24.2005 indicated the patient "declined" 10% in his "Whole Person Improvement" score. This score was a measure from 1.24.04-2.26.04.

There is documentation on 7.15.04 from Dr. Crisp M.D., which demonstrated that the patient had conservative treatment that had failed to rid the patient's symptoms. In the absence of such improvement, the necessity for ongoing conservative intervention was not established, as the care was not realistically expected to produce a favorable outcome. Dr. Crisp did recommend a trial of spinal decompression. The hand-written notes were difficult to read, but did seem to indicate that spinal decompression was performed. The VAS during this period of time generally hovered around 6 on a 0-10 scale. Absent from these records was a sustained reduction in this subjective measure.

Although still an emerging technology, the mechanism of spinal decompression, coupled with the available research (albeit scant and not without its critics) does hold some promise for certain patients. A trial using this technology is justified. However, the disputed services include Manual Therapy (97140,) Neuromuscular Re-education (97112,) and Therapeutic Activities (97530.) These do not describe spinal decompression. Spinal decompression is a form of mechanical traction, which is identified in the 2005 edition of CPT with the code 97012.

In a letter to the carrier disputing the peer review denial, Dr. Naehritz referred to a reduction in the reported VAS and a reduction in the severity of the radicular symptoms. I did consider these comments and I did review the records for indicators to support this. The clinical exam notes do indicate a reduction in the positive orthopedic findings in the time period prior to the period in dispute.

The 6.15.2004 FCE was the 5th such FCE performed. Former and current TWCC literature supports the use of 3 FCEs in conjunction with comprehensive occupational rehabilitation programs as described by CARF. Ongoing use of FCEs to monitor progress outside of this CARF described program is not established.

In regards to the denied phone call (99372), there is documentation that a call was made. A provider-to-provider teleconference is medically necessary to coordinate care and discuss treatment options for the patient. Reimbursement for this phone call is supported.

Clinical Criteria, Utilization Guidelines or other material referenced

- *Occupational Medicine Practice Guidelines*, Second Edition.
- *The Medical Disability Advisor*, Presley Reed MD
- *A Doctors Guide to Record Keeping*, Utilization Management and Review, Gregg Fisher
- *CPT,* 2005 edition

- *CARF* Standards Manual for Medical Rehabilitation, 2005 edition.
- *TWCC Medical Fee Guidelines,* 1996
- *TWCC ADL level 2 training material,* 2003.

The reviewer for this case is a doctor of chiropractic peer matched with the provider that rendered the care in dispute. The reviewer is engaged in the practice of chiropractic on a full-time basis.

The review was performed in accordance with Texas Insurance Code §21.58C and the rules of the Texas Workers Compensation Commission. In accordance with the act and the rules, the review is listed on the TWCC's list of approved providers, or has a temporary exemption. The review includes the determination and the clinical rationale to support the determination. Specific utilization review criteria or other treatment guidelines used in this review are referenced.

The reviewer signed a certification attesting that no known conflicts-of-interest exist between the reviewer and any of the providers or other parties associated with this case. The reviewer also attests that the review was performed without any bias for or against the patient, carrier, or other parties associated with this case.

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 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 Tex. Admin. Code § 148.3). This Decision is deemed received by you 5 (five) days after it was mailed and the first working day after the date this Decision was placed in the carrier representative's box (28 Tex. Admin. Code § 102.5 (d)). A request for hearing should be sent to: Chief Clerk of Proceeding/Appeals , 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 this written request for a hearing to the opposing party involved in the dispute.

I hereby verify that a copy of this Findings and Decision was faxed to TWCC, Medical Dispute Resolution department applicable to Commission Rule 102.5 this 22nd day of July 2005. The TWCC Medical Dispute Resolution department will forward the determination to all parties involved in the case including the requestor, respondent and the injured worker. Per Commission Rule 102.5(d), the date received is deemed to be 5 (five) days from the date mailed and the first working day after the date this Decision was placed in the carrier representative's box.

_____

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.