

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 All Star Chiropractic and Rehab 8208 Bedford-Euless Road North Richland Hills, Texas 76180 | MDR Tracking No. M5-05-2546-01 |
| | TWCC No.: |
| | Injured Employee's Name: |
| Respondent's Name and Address American Home Assurance, Box 19 | Date of Injury: |
| | Employer's Name: |
| | Insurance Carrier's No.: |

PART II: SUMMARY OF DISPUTE AND FINDINGS – Medical Necessity Services

| Dates of Service | | CPT Code(s) or Description | Did Requestor Prevail? |
|------------------|---------|---|---|
| From | To | | |
| 9-3-04 | 11-9-04 | CPT codes 98940, 97110, 97032, 97035, 97012, 97750-FC | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | <input type="checkbox"/> Yes <input 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 **prevailed** on the disputed medical necessity issues. The total amount due the requestor for the medical necessity issues is \$4,937.30.

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. The services, rendered were found were not found to be medically necessary. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 6-23-05 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.

The carrier denied CPT Code 99080-73 on 9-30-04 with a "V" for unnecessary medical treatment based on a peer review; however, the TWCC-73 is a required report per Rule 129.5 and is not subject to an IRO review. A referral will be made to Compliance and Practices for this violation. **Recommend reimbursement of \$15.00.**

PART IV: COMMISSION DECISION AND ORDER

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 the amount of \$4,952.30 for services from 9-3-04 through 11-9-04, 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:

Donna Auby 7-18-05

Ordered by:

Margaret Q. Ojeda 7-18-05

Authorized Signature

Typed Name

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.

Original Review: July 6, 2005
Amended Review: July 15, 2005

TEXAS WORKERS COMP. COMMISSION
AUSTIN, TX 78744-1609

CLAIMANT: ____
EMPLOYEE: ____
POLICY: M5-05-2546-01
CLIENT TRACKING NUMBER: M5-05-2546-01/5278

AMENDED REVIEW

Medical Review Institute of America (MRIoA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Workers Compensation Commission has assigned the above mentioned case to MRIoA for independent review in accordance with TWCC Rule 133 which provides for medical dispute resolution by an IRO.

MRIoA has performed an independent review of the case in question to determine if the adverse determination was appropriate. In performing this review all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the TWCC approved doctor list (ADL). The reviewer has signed a statement indicating they have no known conflicts of interest existing between themselves and the treating doctors/providers for the patient in question or any of the doctors/providers who reviewed the case prior to the referral to MRIoA for independent review.

Records Received:

Records from state:

- TWCC Notification of IRO Assignment 6/22/05 – 1 page
- Letter to MRIoA from TWCC 6/22/05 – 1 page
- Medical Dispute Resolution Request/Response x3 – 3 pages
- List of treating providers – 3 pages
- Table of Disputed Services (updated table) – 8 pages
- Explanation of Reimbursement – 31 pages

Records from provider:

- Letter to SRS from Jon W. Schweitzer, DC 2/22/05 – 4 pages
- Letter to TWCC from Dr. Schweitzer 11/23/04 – 4 pages
- TWCC-69 – Report of Medial Evaluation 11/23/04 – 1 page
- Records from Dr. Schweitzer including Progress Reports 7/7-11/9/04, Initial Functional Capacity Evaluations 10/4/04, 11/5/04, and Initial Consultation 7/6/04 – 58 pages
- Review by Jane T. Duncan, DC 10/22/04 – 4 pages
- Procedure reports, John D. Fisk, MD 10/12/04, 9/28/04 – 6 pages
- Consultation, Mark A. Ritchie, DC 9/30/04, 7/6/04 – 31 pages
- Subjective Progress Report, Dr. Ritchie 9/30/04 – 1 page
- Physical Performance Test (PPT) report 9/30/04 – 3 pages
- PPT including graphs, 9/30/04 – 17 pages
- PPT request 7/16/04 – 1 page
- PPT report 7/16/04 – 3 pages
- Computerized Spinal Range of Motion Exam 7/16/04 – 10 pages
- Service request form 7/16/04 – 1 page
- MRI lumbar spine 6/26/04 – 2 pages
- Medical Dispute Resolution Request/Response – 1 page
- List of treating providers – 1 page
- Table of Disputed Services – 8 pages
- HCFA 1500 forms – 27 pages
- Explanation of Reimbursement – 78 pages
- Duplicates – 3 pages

Summary of Treatment/Case History:

The claimant underwent diagnostic imaging, physical medicine treatments and lumbar ESI after injuring her low back on ___ when she helped move a patient at the hospital where she worked.

Questions for Review:

DOS Disputed: 9/3/04-11/9/04

Were the CMT (#98940), therapeutic exercises (#97110), electrical stimulation-manual (#97032) ultrasound (#97035), mechanical traction (#97012) and functional capacity examination (#97750-FC) medically necessary to treat this patient's injury? Note: Do not review items on table indicated to be fee issues or paid items.

Explanation of Findings:

Expectation of improvement in a patient's condition should be established based on success of treatment. Continued treatment is expected to improve the patient's condition and initiate restoration of function. If treatment does not produce the expected positive results, it is not reasonable to continue that course of treatment. With documentation of improvement in the patient's condition and restoration of function, continued treatment may be reasonable and necessary to effect additional gains.

In this case, there is adequate documentation of objective and functional improvement in this patient's condition. Specifically, her lumbar ranges of motion increased to near normal from 07/16/04 to 11/05/04. Without question, the medical records fully substantiate that the disputed services fulfilled statutory requirements (1) for medical necessity since the patient obtained relief (without surgery), promotion of recovery was accomplished and the employee returned to full employment.

Conclusion/Decision to Certify:

The CMT (#98940), therapeutic exercises (#97110), electrical stimulation-manual (#97032) ultrasound (#97035), mechanical traction (#97012) and functional capacity examination (#97750-FC) were medically necessary to treat this patient's injury.

References Used in Support of Decision:

Texas Labor Code 408.021

This review was provided by a chiropractor who is licensed in Texas, certified by the National Board of Chiropractic Examiners, is a member of the American Chiropractic Association and has several years of licensing board experience. This reviewer has written numerous publications and given several presentations with their field of specialty. This reviewer has been in continuous active practice for over twenty-five years.

MRIOA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the treating provider, payor and/or URA, patient and the TWCC.

It is the policy of Medical Review Institute of America to keep the names of its reviewing physicians confidential. Accordingly, the identity of the reviewing physician will only be released as required by state or federal regulations. If release of the review to a third party, including an insured and/or provider, is necessary, all applicable state and federal regulations must be followed.

Medical Review Institute of America retains qualified independent physician reviewers and clinical advisors who perform peer case reviews as requested by MRIOA clients. These physician reviewers and clinical advisors are independent contractors who are credentialed in accordance with their particular specialties, the standards of the American Accreditation Health Care Commission (URAC), and/or other state and federal regulatory requirements.

The written opinions provided by MRIOA represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to MRIOA for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Medical Review Institute of America assumes no liability for the opinions of its contracted physicians and/or clinician advisors. The health plan, organization or other party authorizing this case review agrees to hold MRIOA harmless for any and all claims which may arise as a result of this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

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