

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 Allied Multicare Centers 415 Lake Air Drive Waco, Texas 76710	MDR Tracking No.: M5-05-2547-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Texas Mutual Insurance Company, Box 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS – MEDICAL NECESSITY ISSUES

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
5-26-04	6-9-04	CPT code 97110, 97112	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
6-11-04	6-11-04	CPT codes 99213	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
5-26-04	8-17-04	CPT codes 97530, 98940, 98941, 97124, 97012	<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.

In accordance with Rule 133.308 (e), requests for medical dispute resolution are considered timely if they are filed with the division no later than one (1) year after the date(s) of service in dispute. The following date(s) of service are not timely and are not eligible for this review: 5-19-04 – 5-21-04.

The Division has reviewed the enclosed IRO decision and determined that the requestor did **not** prevail on the majority of the disputed medical necessity issues. Reimbursement for the medical necessity issues is \$922.68.

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 6-22-05 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 95831-59 (7 units) on 6-10-04 was denied by the carrier as "JM-The code and/or modifier billed is invalid." Per the Medicare Fee Guideline this is a valid code and modifier. Recommend reimbursement of \$192.71 (\$27.53 X 7 units).

PART IV: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor 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. Total reimbursement is \$1,115.39.

Findings and Decision by:

Donna Auby

7-20-05

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.



Specialty Independent Review Organization, Inc.

July 11, 2005

TWCC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient: ____
TWCC #: ____
MDR Tracking #: M5-05-2547-01
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to Specialty IRO for independent review in accordance with TWCC Rule 133.308, which allows for medical dispute resolution by an IRO.

Specialty IRO has performed an independent review of the care rendered 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.

This case was reviewed by a licensed Chiropractor. The reviewer is on the TWCC ADL. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

____ was injured in a motor vehicle accident while working for CTWP on _____. He initially presented to Allied Multicare Center and Micah Mordecai, DC on 2/26/04. His history is positive for comorbid conditions of heart trouble, hepatitis and high blood pressure. He measures 6'1" and weighs 261 lbs according to the records. He underwent passive and active therapies under

Dr. Mordecai's supervision. He was placed at MMI by Dr. Mordecai with a 10% IR on 6/22/04. He saw a DD, David Baugher, DC, on 7/29/04 who assigned a 10% IR based upon a category II cervicothoracic and lumbosacral impairment.

RECORDS REVIEWED

Records were received from the respondent and the treating doctor/requestor. Records from the treating doctor/requestor include the following: 2/26/04 initial narrative report, 3/18/04, 4/29/04 and 6/10/04 subsequent narratives, final narrative/impairment rating of 6/22/04, DD report of 7/29/04 and daily notes report of 2/26/04 through 8/17/04.

Records from the respondent the following records which are in addition to those mentioned above: 6/27/05 letter by Ron Nesbitt of TX Mutual, query of treatment and services by all providers chart from TX Mutual, 2/25/04 radiology report by Hillcrest Baptist Medical Center, 8/25/04 daily note by Dr. Mordecai, 7/29/04 note from David Baugher, DC to Shawn Fyke, DC indicating a shoulder series is to be performed on a Travonne Collins (unrelated to this review) and a 7/29/04 note by Shawn Fyke, DC.

DISPUTED SERVICES

Disputed services include the following: 97110, 97112, 97530, 98940, 98941, 97124, 99213 and 97012 from 5/26/04 through 8/17/04.

DECISION

The reviewer disagrees with the previous adverse determination regarding the following services on the following specific dates: 99213 (6/11/04), four units of 97110 per date of service (5/26/04 through 6/09/04), 97112 (5/26/04 through 6/9/04).

The reviewer agrees with the previous adverse determination regarding all remaining services.

BASIS FOR THE DECISION

The reviewer indicates that the report of 6/10/04 indicates there was a report on 5/12/04; however, no such report was included in the documentation provided by the requestor or the respondent. The patient's range of motion increased from 2/26/04 through 3/18/04 by an average of approximately 26% in the cervical spine and 40% in the lumbar spine. Upon the examination of 4/29/04 the range of motion had decreased in virtually all areas; however, the patient's physical capacity lift tests had increased in most areas by a good margin. As noted the 5/12/04 exam was not included. The 6/10/04 notes indicate a possible lack of patient effort secondary to consistently low ROM in all areas and all the work capacity lift tests have decreased significantly except for high far lift, back lift and leg lift. The notes were generally lacking in pain scales to help track pain reduction.

The reviewer indicates disagreement with Mr. Nesbitt of Texas Mutual regarding the necessity of treatment greater than 30-45 minutes as per Medicare guidelines. This is based upon a single area of injury based upon a noncomplicated presentation in an elderly population. Mr. ___ is moderately obese and has multiple comorbid conditions, which would likely slow healing. Secondly, it is difficult to determine this gentleman's PDL, as it is not mentioned in the records. According the MDA by Presley Reed, the following is the normative data for disability with medical treatment.

Medical treatment.

Job Classification	Minimum	Optimum	Maximum
<i>Sedentary</i>	1	7	14
<i>Light</i>	1	14	21
<i>Medium</i>	1	21	42
<i>Heavy</i>	1	56	91
<i>Very Heavy</i>	1	91	168

REFERENCES

Malone, Terry R., Thomas McPoil, and Arthur J. Nitz. Orthopedic and Sports Physical Therapy. St. Louis: Mosby, 1997.

Reed, P, Medical Disability Advisor, Internet

Van Tulder MW, Malmivaara A, Esmail R, Koes BW.. Exercise therapy for low-back pain. The Cochrane Database of Systematic Reviews 2000, Issue 2. Art. No.: CD000335. DOI: 10.1002/14651858.CD000335.

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that there is no known conflict between the reviewer, Specialty IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,

Wendy Perelli, CEO
CC: Specialty IRO Medical Director