

# 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<br>Pain & Recovery Clinic of North Houston<br>6660 Airline Drive<br>Houston, Texas 77076 | MDR Tracking No.: M5-05-2666-01       |
|   | TWCC No.:                             |
|   | Injured Employee's Name:              |
| Respondent's Name and Address<br>North American Specialty Insurance<br>Box 22   | 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       |                                      |   |
| 05-21-04         | 09-10-04 | 99212, 97140, 97032, 97110 and 97112 | <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 not** prevail on the disputed medical necessity issues.

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 07-08-05, 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 codes 99212, 97110, 97140, 97032 and 97112 dates of service 06-01-04, 06-03-04, 06-08-04, 06-10-04 and 06-15-04 denied with denial code "F" (disallowed; services appear to have been performed by another provider). Per the approved TWCC-53 the treating doctor was Warren B. Dailey, M.D. until June 1, 2004 at which time the treating doctor was changed to Dean McMillan, M.D. Per Rule 134.801(e)(1-4) the requestor was not the treating doctor of record. No reimbursement is recommended.

CPT codes 99212, 97110, 97140 and 97112 dates of service 06-25-04 and 06-30-04 denied with denial code "L" (disallowed: this provider is not on file as the treating doctor for this patient). Per the approved TWCC-53 the treating doctor was Warren B. Dailey, M.D. until June 1, 2004 at which time the treating doctor was changed to Dean McMillan, M.D. Per Rule 134.801(e)(1-4) the requestor was not the treating doctor of record. No reimbursement is recommended.

**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 reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

\_\_\_\_\_  
Authorized Signature

08-11-05

\_\_\_\_\_  
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**

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 5, 2005

**To The Attention Of:** TWCC  
7551 Metro Center Drive, Suite 100, MS-48  
Austin, TX 78744-16091

**RE: Injured Worker:** \_\_\_\_\_  
**MDR Tracking #:** M5-05-2666-01  
**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
- Examination reports
- TWCC forms
- Surgical notes
- History reports
- Daily therapy notes
- X-ray reports
- MRI reports
- All medical examinations
- Designated doctor reports

**Note:** There was a large stack of documentation supplied by TWCC that appears to be identical to the documentation supplied by the provider.

**Submitted by Respondent:**

- Medical peer review reports
- Medical narrative reports
- Physical therapy reports
- Chronic pain management reports
- Daily notes
- X-ray reports
- MRI reports
- Designated doctor reports
- Surgical notes
- Therapy notes
- Counseling notes

**Clinical History**

According to the supplied documentation, the claimant was employed at \_\_\_\_\_ and sustained an injury on \_\_\_\_\_. The claimant reported that she slipped and fell on a waxed floor at school and reported injuries of pain in her neck and back. The claimant was seen at McGregor Medical Association and was diagnosed with back and neck pain secondary to a fall. Plain film x-rays were taken the same day and revealed degenerative changes at C5-C6 with no acute fracture or subluxation. The lumbar spine revealed normal alignment with no evidence of acute fracture or dislocation. On 1/31/01, the claimant underwent an MRI of the brain which revealed no evidence of an acute intercranial process. An MRI was also performed on the cervical spine on 1/31/01 that revealed degenerative disease at C5-6 with a bulging disc at this level with a left paracentral disc protrusion with no obvious cord compression. There was also degenerative changes of the uncinat process on the right at this level resulting in moderate right foraminal stenosis. The remainder of the examination was unremarkable. On 3/13/01, the claimant underwent another MRI of the cervical spine which revealed similar findings. The claimant was seen by various medical providers and was eventually referred to Ajay K. Bindal, M.D. Dr. Bindal performed an anterior cervical discectomy and fusion at C5-6 and at C6-7 on 9/17/01. Dr. Bindal performed a follow-up on 12/26/01 and reported that the claimant was doing well with marked improvement of her condition and complaints. Medical treatment continued on the claimant. On 12/15/02, the claimant was deemed at maximum medical improvement with a 10% whole person impairment by Joseph Anthony Walter III, M.D. On 3/19/03, the claimant was referred by Dr. Jeffrey Reuben for a chronic pain management evaluation. On 1/3/03, Nester Martinez, D.C. also reported the claimant was at maximum medical improvement as of 12/15/02 with a 19% whole person impairment. The therapy continued through 2003. The dates of service in question in 2004 were reviewed for medical necessity.

### **Requested Service(s)**

Office visits (99212), manual therapy technique (97140), electrical stimulation (manual) (97032), therapeutic exercises (97110) and neuromuscular re-education (97112).

### **Decision**

I agree with the insurance carrier that the requested services are not medically necessary.

### **Rationale/Basis for Decision**

According to the supplied documentation, it appears that the claimant sustained an injury to her cervical spine in relation to her compensable work injury dated \_\_\_\_\_. The claimant underwent large amounts of treatment including surgery to her cervical spine, medical treatment, chiropractic treatment as well as physical therapy treatment. After the surgery, the claimant underwent an adequate amount of physical therapy to help reduce her symptoms, although the claimant still complained of ongoing pain. Different treatment options were introduced including a chronic pain management program. The claimant had a lapse in care prior to the dates of service in question and reported back to her treating physician that she still had continued cervical pain and even noting that it was worse than prior to the surgery. The claimant was placed at maximum medical improvement as of 12/15/02 by two separate doctors and it was determined that she was at maximum medical improvement. There was a discrepancy between the two, with one placing her at a 10% whole person impairment while the other placed her at a 19% impairment. Although the amount of impairment differed between the two evaluating physicians, the date of maximum medical improvement was not under dispute. The dates of service in question are approximately 16 months after two physicians reported the claimant was at maximum medical improvement. The therapy rendered included daily office visits, manual therapy, electrical stimulation, therapeutic exercises and neuromuscular re-education. All of these treatment modalities had been performed and failed in prior trials with the claimant. The move to reintroduce the same treatment modalities was not objectively supported by the documentation and is not supported by current medical literature. Continued and ongoing doctor supervised therapy is considered unreasonable in the treatment of the compensable injury. No supervised therapeutic exercises or passive modalities appear reasonable and medically necessary in the treatment of the \_\_\_\_\_ compensable work injury.

**Note:** During the entire review of the file it was noted that the claimant had various complaints in her lumbar spine, but in a TWCC decision the lumbar spine was deemed not compensable in relation to the work injury of \_\_\_\_\_; therefore, it was not reviewed for the decision above.

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 5<sup>th</sup> day of August 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder