Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity and Fee Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address: Pain & Recovery Clinic C/O Bose Consulting, LLC PO BOX 550496 Houston, Texas 77255	MDR Tracking No.: M5-05-2738-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: American Zurich Insurance Company Box 19	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documentation submitted included TWCC-60, explanation of benefits, CMS 1500s and medical documentation. Position summary is that the treatment was necessary.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documentation submitted included carrier response to the TWCC-60 and copy of peer review. Position summary is this is a fee dispute involving retrospective medical necessity. The carrier disputes that the provider has shown that the treatment underlying the charges was medically reasonable and necessary.

PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
06-28-04 to 10-13-04	99212, 99214, 97032, 97140, 97112, 97110 and E1399	☐ Yes ☒ No	$0.00

PART V: 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 Division Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), Medical Dispute Resolution 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 therefore no reimbursement is due.

Based on review of the disputed issues within the request, the 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 Medical Dispute Resolution.

On 07-15-05, 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.

Review of CPT codes 99212, 97110, 97112, 97032, 97140 and HCPCS code E1399 dates of service 10-18-04 through 11-03-04 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing evidence of carrier receipt of the providers request for EOBs. No reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and Rule 133.307(e)(2)(B)

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the 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:

		09-16-05
Authorized Signature	Typed Name	Date of Findings and Decision

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and 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. The Division is not considered a party to the appeal.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

Parker Healthcare Management Organization, Inc.
4030 N. Beltline Road, Irving, TX 75038
972.906.0603 972.255.9712 (fax)
Certificate # 5301

September 7, 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: M5-05-2738-01
RE: Independent review for ___

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

- Parker Healthcare Management received notification of independent review on 7.14.05.
- Faxed request for provider records made on 7.14.05.
- TWCC issued an Order for Payment from requestor on 8.3.05.
- The case was assigned to a reviewer on 8.15.05.
- The reviewer rendered a determination on 9.6.05.
- The Notice of Determination was sent on 9.7.05.

The findings of the independent review are as follows:

Questions for Review

Office visits (99212,99214), E-Stimulation (manual)(97032), manual therapy (97140), neuromuscular re-education (97112), therapeutic exercises (97110), DME (E1399). Dates in dispute are 06.28.04 through 11.03.04. Items on table marked as “FEE” were not reviewed.

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 **uphold the denial** on the disputed service(s).

Summary of Clinical History

Mr. ___ underwent diagnostic imaging, examinations and physical medicine treatments after injuring his lumbar spine. He had attempted to lift a 120-pound block of concrete while working on ___.

Clinical Rationale

Physical medicine is an accepted part of a rehabilitation program following surgery. However, for medical necessity to be established there must be an expectation of recovery or improvement within a reasonable and generally predictable time period. In addition, the frequency, type and duration of services must be reasonable and consistent with the standards of the health care community. General expectations include: (A) As time progresses, there should be an increase in the active regimen of care, a decrease in the passive regimen of care and a decline in the frequency of care. (B) Home care programs should be initiated near the beginning of care, include ongoing assessments of compliance and result in fading treatment frequency. (C) Patients should be formally assessed and re-assessed periodically to see if the patient is moving in a positive direction in order for the treatment to continue. (D) Supporting documentation for additional treatment must be furnished when exceptional factors or extenuating circumstances are present. (E) Evidence of objective functional improvement is essential to establish reasonableness and medical necessity of treatment.

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. In this case, there is no documentation of objective or functional improvement in this patient's condition and no evidence of a change of treatment plan to justify additional treatment in the absence of positive response to prior treatment.

More importantly, the records failed to substantiate that the disputed services fulfilled statutory requirements [1] for medical necessity since the patient obtained no relief, promotion of recovery was not accomplished and there was no enhancement of the employee's ability to return to employment. Specifically, there is no documentation that the recovery was promoted or that the employee returned to work. In regard to relief of pain, the claimant's pain rating was 5/10 on 06.28.04 at the initiation of the disputed treatment and was 6/10 on 11.03.04 at the termination of the disputed treatment.

Clinical Criteria, Utilization Guidelines or other material referenced

- Texas Labor Code 408.021

This conclusion is supported by the reviewers' clinical experience with over 8 years of patient care.

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.

[1] Texas Labor Code 408.021

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 7th day of September, 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.