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:	MDR Tracking No.: M5-05-2759-01
Pain & Recovery Clinic C/o Bose Consulting, LLC P O BOX 550496 Houston, Texas 77255	Claim No.: Injured Employee's Name:
Respondent's Name and Address: Ace American Insurance Company Box 15	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor submitted TWCC-60, CMS 1500s, explanation of benefits and medical documentation. Requestor position summary: The treatment provided to the patient has been medically reasonable and necessary based on accepted medical protocols and Texas Labor Code.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No response received from carrier.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
12-21-04 to 01-28-05	97032 ($20.03 X 4 DOS 2004 = $100.15) 97032 ($20.34 X 10 DOS 2005 = $203.40) 97140 ($33.91 X 1 DOS 2004) = $33.91) 99212 ($48.03 X 4 DOS 2004 = $192.12) 99212 ($49.41 X 10 DOS 2005 = $494.10) 99214 ($104.79 X 1 DOS 2004 = $104.79) 97110 ($111.12 X 4 DOS 2004 = $444.48) 97110 ($107.58 X 10 DOS 2005 = $1,075.80) 97112 ($36.75 X 4 DOS 2004 = $147.00) 97112 ($37.78 X 10 DOS 2005 = $377.80) E1399 ($20.00 X 4 DOS 2005 = $80.00) 97035 ($15.78 X 5 DOS 2004 = $78.90) 97035 ($15.53 X 10 DOS 2005 = $155.30) 97124 ($28.07 X 1 DOS 2004 = $28.07)	☒ **Yes** ☐ **No**	$3,515.82

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 **prevailed** on the disputed medical necessity issues. The amount due from the carrier for the medical necessity issues is noted above.

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 07-19-05, 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 99080-73 date of service 12-20-04 denied with denial code "V" (unnecessary treatment with peer review). Per Rule 129.5 this is a required report and not subject to an IRO review. The Medical Review Division has jurisdiction. Reimbursement is recommended in the amount of **$15.00.** A Compliance and Practices referral will be made.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and Rule 129.5

PART VII: DIVISION DECISION AND ORDER

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 entitled to additional reimbursement in the amount of $3,530.82_. In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of $460.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30 days of receipt of this Order.

Findings and Decision and Order by:

		09-26-05
Authorized Signature		Date of Order

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.

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive Austin, Texas 78738

Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-05-2759-01
Name of Patient:	___
Name of URA/Payer:	Pain & Recovery Clinic c/o Bose Consulting
Name of Provider: (ER, Hospital, or Other Facility)	Pain & Recovery Clinic
Name of Physician: (Treating or Requesting)	William Hicks, DC

September 8, 2005

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Texas Workers Compensation Commission

CLINICAL HISTORY

The following are observations and formulated opinions made solely from documentation available for review which included:

MDR Request Response materials
Position Statement – Bose Consulting, LLC
MRI Reports – Edward Knudson, MD
EMG/NCV Reports – Jeff Hamilton, DC
Designated Doctor Reports – Mool Nigam, MD
Pain Management & ESI Reports – Andrew McKay, MD
Orthopedic Reports – Kenneth Berliner, MD
FCE Reports – Wayne Parks, DC
Treating Doctor's Notes & Reports – William Hicks, DC
Billing Statements & EOBs – VT/AIG-GAB Robins

Available information suggests that this patient reports experiencing an occupational MVA on ___ involving injuries to his neck and lower back. He was taken to the emergency room where he received x-rays, but no reports of this are provided for review. The patient later presents to a chiropractor, William Hicks, DC, where he begins a course of conservative therapy consisting of active and passive modalities. MRI performed 11/10/04 suggests multiple cervical disc protrusions with degenerative osteophyte formation, and lumbar disc protrusions with midline annular tear at L5/S1. The patient is referred for pain management and epidural steroid injections with an Andrew

McKay, MD, on 11/29/04. Orthopedic evaluation is made with Kenneth Berliner, MD on 01/24/05, recommending ESIs and physical therapy. Designated doctor evaluation is made 04/01/05 with a Mool Nigam, MD, indicating that the patient had not achieved MMI and that completion of ESIs and post injection physical therapy was clinically indicated. Carrier does indicate from available EOBs that treatments are determined unnecessary both "without" and "with peer review." No peer review reports or carrier position documentation is provided for review

REQUESTED SERVICE(S)
Determine medical necessity for office visits (99212, 99214) therapeutic exercises (97110), neuromuscular reeducation (97112), manual therapy (97140), electric stimulation (97032), ultrasound (97035), massage (97124) and DME (E1399) for period in dispute 12/21/04 through 01/28/05.

DECISION
Approved.

RATIONALE/BASIS FOR DECISION
Medical necessity for these treatments and services (12/21/04 through 01/28/05) **do appear medically necessary and clinically indicated** per supporting documentation and specifically designated doctor report of 04/01/05. As the carrier has not provided IME, RME or Peer Review documentation (*) in opposition of these findings, the provider has submitted reasonable documentation to support the treatment as provided.

*[TWCC rule 133.304 (g) (1,2,3)]
1. Philadelphia Panel Evidence-Based Clinical Practice Guidelines on Selected Rehabilitation Physical Therapy, Volume 81, Number 10, October 2001.
2. Hurwitz EL, et al. The effectiveness of physical modalities among patients with low back pain randomized to chiropractic care: Findings from the UCLA Low Back Pain Study. J Manipulative Physiol Ther 2002; 25(1):10-20.
3. Haas M, Goldberg B, Aickin M, et al. A practice-based study of patients with acute and chronic low back pain attending primary care and chiropractic physicians: two-week to 48-month follow-up. *Journal of Manipulative and Physiological Therapeutics* 2004;27:160-169.

4. Harris GR, Susman JL: "Managing musculoskeletal complaints with rehabilitation therapy" Journal of Family Practice, Dec, 2002.
5. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Mercy Center Consensus Conference, Aspen Publishers, 1993.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials.

No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned individual. These opinions rendered do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.