

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 Health and Medical Practice 324 N. 23 rd St. Ste #201 Beaumont, TX 77707	MDR Tracking No.: M5-05-2808-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address TX Mutual Insurance Company, Box 54	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		
12-27-04	3-17-05	CPT codes 95900, 97124, 97530	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
12-27-04	3-17-05	CPT codes 95904, 97032	<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 majority of the disputed medical necessity issues. The total due the requestor for the medical necessity services is \$1,220.12.

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.

On 7-14-05 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.

Regarding 3 units of CPT code 97530 on 2-24-05: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). Per Rule 133.307 (e)(2)(A) a copy of all medical bills as originally submitted to the carrier for reconsideration in accordance with 133.304 must be provided to the Commission. Recommend no reimbursement.

CPT code 95904-WP on 3-7-05 and 3-9-05 was denied by the carrier as "892-this code is invalid." Per the 2002 MFG WP is not a valid modifier. Recommend no reimbursement.

Regarding CPT code 95900 on 2-24-05: Two units of this service were paid by the insurance carrier. Two units were denied as “217 – The value of this procedure is included in another procedure billed on this date.” However, no other services were billed on this date. Recommend reimbursement of \$149.18 (\$74.59 X 2 DOS).

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, totaling \$1,369.30, 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

8-26-05

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 en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

August 23, 2005

TEXAS WORKERS COMP. COMMISSION
AUSTIN, TX 78744-1609

CLAIMANT: ____

EMPLOYEE: ____

POLICY: M5-05-2808-01

CLIENT TRACKING NUMBER: M5-05-2808-01-5278

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 RECEIVED FROM THE STATE:

Notification of IRO Assignment dated 7/14/05, 41 pages

RECORDS RECEIVED FROM REQUESTOR:

Requests for Reconsideration 5/20/05, 6 pages

IRO Letter 7/22/05, including TWCC guidelines, 22 pages

Daily Notes Reports, Dr. Patrick McMeans, MD 12/22/04 – 3/17/05, 28 pages

Initial Report 12/21/04, 6 pages

X-ray Report 12/21/04, 1 page

Initial Medical Consultation 12/21/04, 1 page

Activities of Daily Living 12/21/04, 1 page

Pain Silhouette 12/21/04, 1 page

Diagnostic X-Ray and Physiotherapy Prescriptions 12/23/04, 2/3/05, 12/29/04, 12/30/04, 1/3/05, 2/28/05, 3/3/05, 2/24/05, 3/7/05, 3/9/05, 11 pages

Motor Nerve Conduction Velocity Study 12/29/04, 12/30/04, 2/28/05, 3/3/05, 2/24/05, 5 pages

Progress Notes with duplicates 1/3/05, 1/5/05, 1/26/05, 3/7/05 3/9/05, 4/25/05, 5/25/05, 4/20/05, 24 pages

Nerve Conduction Threshold (CPT) Test results 1/3/05, 6 pages, 1/5/05, 2 pages, 3/7/05, 4 pages, 3/9/05, 2 pages

Referral Form 1/28/05, 1 page

Functional Capacity Evaluation 1/6/05, 20 pages

Functional Capacity Evaluation 3/22/05, 21 pages

Supplemental Report (12 visit) ____, 7 pages

Supplemental Report (24 visit) 3/9/05, 8 pages

Radiology reports, 2/1/05, 2/2/05, 2/3/05, 3 pages

TWCC work status report, 2 pages

Orthopedic evaluation letter dated 5/5/05, 9 pages

Physiotherapeutic notes 12/23/04-3/17/05, 22 pages

Summary of Treatment/Case History:

The claimant is a 28 year old gentleman who allegedly suffered a workplace injury on _____. Subsequently he developed neck and shoulder pain with radiation to the right arm, low back pain with radiation to the buttocks and headaches. He has undergone NCV tests and CPT tests, as well as extensive physical therapy including electrical stimulation, cervical traction, massage and active exercises.

Questions for Review:

1. Were the Electrical Stimulation #97032; Nerve Conduction Study w/o F-Wave #95900; Sensory Nerve Conduction Study #95904; Massage #97124; & Therapeutic Activities #97530 from 12/27/04 to 3/17/05 medically necessary?

Explanation of Findings:

1. Were the Electrical Stimulation #97032; Nerve Conduction Study w/o F-Wave #95900; Sensory Nerve Conduction Study #95904; Massage #97124; & Therapeutic Activities #97530 from 12/27/04 to 3/17/05 medically necessary?

The Current Perception Tests (Sensory Nerve Studies) on 1/3/04 and 1/5/05 were not medically necessary. Current Perception Tests have not been proven to contain diagnostic information that is useful in determining etiology of pain or in treatment planning. The motor nerve conduction velocity tests of 12/29/04 and 12/30/04 were medically necessary even though negative. The use of office-based electrical stimulation is not medically necessary since electrical stimulators are safe and available for home use after one or two sessions to train the patient in their use. The remainder of the physical therapy modalities were medically necessary.

Conclusion/Decision to Certify:

Certify the motor nerve conduction velocity studies (#95900), massage (#97124) and therapeutic activities (#97530)

Conclusion/Decision to Not Certify:

Do not certify the Current Perception Threshold studies (#95904) or the electrical stimulation therapy (#97032) as medically necessary.

Applicable Clinical of Scientific Criteria or Guidelines Applied in Arriving at Decision:

Texas Definition of Medical Necessity (Texas Labor Code §408.021):

An employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that:

- 1) cures or relieves the effects naturally resulting from the compensable injury;
- 2) promotes recovery, or
- 3) enhances the ability of the employee to return to or retain employment.

References Used in Support of Decision:

Chong, P S and Cros, D P (2004). Technology literature review: quantitative sensory testing. *Muscle Nerve* 29:734-47

Hattori, M, et al. (2002). Research on the effectiveness of intermittent cervical traction therapy, using short-latency somatosensory evoked potentials. *J Orthop Sci* 7:208-16

Constantoyannis, C, et al. (2002). Intermittent cervical traction for cervical radiculopathy caused by large-volume herniated disks. *J Manipulative Physiol Ther* 25:188-92

Carroll, D, et al. (2001). Transcutaneous electrical nerve stimulation (TENS) for chronic pain. *Cochrane Database Syst Rev* CD003222

Glaser, J, et al. (2001). Electrical Muscle Stimulation as an Adjunct to Exercise Therapy in the Treatment of Non-Acute Low Back Pain: A Randomized Trial. *The Journal of Pain* 2:295-300

The physician providing this review is board certified in Anesthesiology. The reviewer holds additional certification in Pain Medicine from the American Board of Pain Medicine. The reviewer is a diplomate of the national board of medical examiners. The reviewer has served as a research associate in the department of physics at MIT. The reviewer has received his PhD in Physics from MIT. The reviewer is currently the chief of Anesthesiology at a local hospital and is the co-chairman of Anesthesiology at another area hospital. The reviewer has been in active practice since 1978.

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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