



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:<br><br>Southeast Health Services<br>P. O. Box 170336<br>Dallas, Texas 75217 | MDR Tracking No.:        | M5-05-2941-01 |
|   | Claim No.:               |               |
|   | Injured Employee's Name: |               |
| Respondent's Name and Address:<br><br>Dallas ISD, Box 42  | Date of Injury:          |               |
|   | Employer's Name:         |               |
|   | Insurance Carrier's No.: |               |

#### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included TWCC 60 form, Explanations of Benefits and CMS 1500's. Upon the initial peer review, sufficient documentation was not provided to show the extent of the patient's injuries. Please see the attached further documentation of an MRI report showing disc protrusion and an abnormal EMG/NCV for further review and reconsideration.

#### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No position summary or documents were received.

#### 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) |
|--------------------|---|---|--------------------------------|
| 7-15-04 – 8-6-04   | CPT code 98940  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$403.32                       |
| 7-15-04 – 1-26-05  | CPT codes 98943, 97140-59, 97032, 97016, 97035, 97012, 97799, 99211, 99212, 95851, 95831, 97750, 93799, 97110 | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | -0-                            |
|                    |   |   |                                |
|                    |   |   |                                |

#### 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 majority of the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$403.32.

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 8-3-05 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 on 7-16-04, 8-16-04, and 9-7-04 was denied by the carrier with a "V" for unnecessary medical treatment based on a peer review; however, the TWCC-73 is a required report per Rule 129.5 and is not subject to an IRO review. A referral will be made to Compliance and Practices for this violation. Recommend reimbursement of \$45.00 (\$15.00 X 3 DOS).

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. 133.308

28 Texas Administrative Code Sec. 133.304

**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 parties are instructed to review the IRO decision and take appropriate action. For any services that may have been found to be medically necessary, the insurance carrier is instructed to process those services through their bill review and payment processes, including issuing any additional amounts due consistent with the established fee guidelines. The requestor is not entitled to a refund of the IRO fee. 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 \$448.32. 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:

Donna Auby

9-16-05

Authorized Signature

Typed Name

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.**

September 2, 2005

TEXAS WORKERS COMP. COMMISSION  
AUSTIN, TX 78744-1609

CLAIMANT: \_\_\_\_

EMPLOYEE: \_\_\_\_

POLICY: M5-05-2941-01

CLIENT TRACKING NUMBER: M5-05-2941-01 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 state:

TWCC Notification of IRO Assignment 08/04/05, 26 pages

Records received from requestor:

Letter of Medical Necessity, Bryan Weddle, DC 01/05/05

Treatment plan 07/13/04, 08/26/04

Narrative report, Dr. Weddle

Texas Worker's Compensation Work Status Report, Dr. Weddle 07/16/04, 08/16/04, 08/20/04, 09/07/04

MRI of lumbar spine, Eric S. Bennos, MD 07/08/04

Radiographic report, Darrell Hobson, DC 06/25/04

Procedure note, Charles Willis, MD 09/15/04

Lower Extremity Electrodiagnostic Study, Jonathan Walker, MD 10/20/04

Followup report, Dr. Willis 10/26/04, 12/21/04, 01/18/05

Consult, Francisco Battle, MD 11/10/04

Followup, Dr. Battle 01/07/05

PPE 08/13/04

Interim FCE 09/03/04

TWCC-69 – Report of Medical Evaluation

Impairment rating, Dr. Weddle 01/21/05

Office notes, Dr. Weddle 07/15/04-01/26/05

Records received from Respondent:

Peer review report, Lloyd Payne, BS, DC 09/13/04, 07/16/04

Response to a peer review, Dr. Weddle

**Summary of Treatment/Case History:**

The claimant underwent diagnostic imaging and physical medicine treatments after injuring his lumbar spine when he fell from stilts at work on \_\_\_\_.

**Questions for Review:**

Items in dispute: #98940 and #98943-Chiropractic manipulation, #97140-59, manual therapy technique, #97032 electrical stimulation, #97016, vasopneumatic devices, #97035 ultrasound, #97012 mechanical traction, #97799 unlisted physical medicine/rehab, #99211 and #99212 office visits, #95851-ROM, #95831 muscle testing, #97750 physical performance test, #93799 unlisted cardiovascular service, #97110 therapeutic exercises denied by the carrier for medical necessity.

1. Were the treatments and examinations from 07/15/04 through 01/26/05 medically necessary to treat this patient's injury?

**Explanation of Findings:**

The chiropractic manipulations (#98940) from 07/15/04 through 08/06/04 are medically necessary. All other treatments, procedures and examinations are not medically necessary.

Rationale: Based solely on the carrier reviewer's 07/16/04 report that stated that 6 weeks of treatment (that began on 06/25/04) would be reasonable, the chiropractic manipulations (#98940) from 07/15/04 through 08/06/04 are medically necessary.

Physical medicine is an accepted part of a rehabilitation program following an injury. 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 thus no basis to support the medical necessity of the other treatments.

Specifically, in regard to the passive treatments, it is the position of the Texas Chiropractic Association (reference 1) that it is beneficial to proceed to the rehabilitation phase (if warranted) as rapidly as possible, and to minimize dependency upon passive forms of treatment/care since studies have shown a clear relationship between prolonged restricted activity and the risk of failure in returning to pre-injury status. The TCA Guidelines also state that repeated use of acute care measures alone generally fosters chronicity, physician dependence and over-utilization and the repeated use of passive treatment/care tends to promote physician dependence and chronicity. The ACOEM Guidelines (reference 2) state that passive modalities such as massage, diathermy, TENS units, have no proven efficacy in treating acute low back symptoms and that there is no high-grade scientific evidence to support the effectiveness of passive modalities such as traction, heat/cold applications, massage, diathermy, ultrasound, or TENS units for cervical spine conditions. Therefore, there is no support for the passive treatments that were rendered during time frame in question.

The records also fail to substantiate that the aforementioned services fulfilled the statutory requirements (reference 3) for medical necessity since the patient obtained little to no relief, promotion of recovery was not accomplished and there was no enhancement of the employee's ability to return to employment.

**Conclusion:**

Decision to Certify:

The chiropractic manipulations (#98940) from 07/15/04 through 08/06/04 are medically necessary.

Decision to Not Certify:

All other treatments, procedures and examinations are not medically necessary.

**References Used in Support of Decision:**

- 1) Quality Assurance Guidelines, Texas Chiropractic Association.
- 2) *ACOEM Occupational Medicine Practice Guidelines: Evaluation and Management of Common Health Problems and Functional Recovery in Workers, 2nd Edition*, p. 299.
- 3) Texas Labor Code 408.021

---

This review was provided by a chiropractor who is licensed in Texas, certified by the National Board of Chiropractic Examiners, is a member of the American Chiropractic Association and has several years of licensing board experience. This reviewer has written numerous publications and given several presentations with their field of specialty. This reviewer has been in continuous active practice for over twenty-five years.

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.

1175467.1

lb