



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: Real Health Care 12605 East Freeway, Suite 507 Houston, Texas 77015	MDR Tracking No.: M5-05-3060-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Box 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION PROVIDED: TWCC-60, CMS 1500s and explanation of benefits.
POSITION SUMMARY: Documentation supports medical necessity.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION PROVIDED. Response to TWCC-60 and explanation of benefits.
POSITION SUMMARY: This dispute involves the carrier's payment for date of service 7-15-2004 to 12-29-2004. The requester billed \$14,893.28; Texas Mutual paid \$0.00. The requester believes it is entitled to an additional of \$9,637.27.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
07-19-04 to 09-04-04	99212 (20 units @ \$48.03 per unit) = \$960.60 97032 (8 units @ \$20.04 per unit) = \$160.32 97035 (1 unit @ \$15.78 per unit) = \$15.78 97140 (29 units @ \$33.91 per unit) = \$983.39 97110 (13 units @ \$37.04 per unit) = \$481.52	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2,601.61
09-05-04 to 12-29-04	99212, 97032, 97035, 97140 and 97110	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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 **majority** of disputed medical necessity issues.

The requestor on 09-29-05 submitted an updated table of disputed services which is used for the review.

Dates of service 07-15-04 and 07-16-04 were not timely filed per Rule 133.308(e)(1) and will not be a part of the review.

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 Medical Dispute Resolution.

On 08-17-05, 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 97110 date of service 10-20-04 (3 units) denied with denial codes "143/420" (portion of payment deferred/supplemental payment). The carrier has paid \$51.69. CPT code 97110 (2 units) date of service 10-27-04 revealed that neither party submitted a copy of an EOB. The carrier made a payment of \$31.73 on one unit per the table of disputed services. Per Rule 133.307(e)(2)(b) the requestor provided convincing evidence of carrier receipt of the providers request for an EOB. CPT code 97110 date of service 10-29-04 (2 units) and 11-03-04 (3 units) denied with denial code "F" (Fee Guideline MAR reduction). The carrier made a payment of \$68.92 on date of service 10-29-04. No payment was made by the carrier on date of service 11-03-04. Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one". The requestor did not submit documentation for review. Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light of all of the Commission requirements for proper documentation. No additional reimbursement is recommended.

Review of CPT code 97032 (1 unit) date of service 08-13-04 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the requestor submitted convincing evidence of carrier receipt of the providers request for an EOB. Reimbursement per Rule 134.202(c)(1) is recommended in the amount of **\$20.04 (\$16.03 X 125%)**.

Review of CPT code 99212 date of service 08-18-04 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the requestor submitted convincing evidence of carrier receipt of the providers request for an EOB. Reimbursement per Rule 134.202(c)(1) is recommended in the amount of **\$48.03 (\$38.42 X 125%)**.

CPT code 97140-59 date of service 10-26-04 denied with denial code -N- (not appropriately documented). The requestor did not submit documentation for review. No reimbursement recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, Rule 134.202(c)(1), Rule 133.308(e)(1) and Rule 133.307(e)(2)(B)

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 reimbursement in the amount of \$2,669.68.

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. In addition, the Division finds that the requestor was not the prevailing party and is not entitled to a refund of the IRO fee.

Findings and Decision and Order by:

09-30-05

Authorized Signature

Date of Findings and Decision and 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.



7600 Chevy Chase, Suite 400
Austin, Texas 78752
Phone: (512) 371-8100
Fax: (800) 580-3123

NOTICE OF INDEPENDENT REVIEW DECISION

Date: September 7, 2005

To The Attention Of:

DWC
7551 Metro Center Drive, Suite 100, MS-48
Austin, TX 78744-16091

RE: Injured Worker:

MDR Tracking #: M5-05-3060-01

IRO Certificate #: IRO 5263

Forté has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Division of Workers' Compensation (DWC) at the Texas Department of Insurance has assigned the above referenced case to Forté for independent review in accordance with DWC 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:

- Request for Independent Review dated 8/19/05 from Real Health Care
- Daily SOAP Notes from Real Health Care dates 7/30/04-12/29/04
- Exercise Log Sheet dates 7/30/04-12/29/04
- Initial Medical Report dated 7/12/04 from Real HealthCare Chris Davis, D.C.
- Progress Report dates 8/14/04, 9/15/04, 10/11/04, 11/10/04 and 12/13/04 from Real Health Care John Randolph, D.C.
- Functional Capacity Evaluation dated 1/14/04 and 1/25/05 from Bingle Crossing Chiropractic Clinic
- Operative Report dated 12/9/04 from Texas Surgicom Ihsan Shanti, M.D.
- Assessment/Physical Examination dated 7/26/04 from Ihsan Shanti, M.D.

Submitted by Respondent:

- None submitted

Clinical History

Mr. ___ is a 58-year-old male who allegedly injured his low back while employed with _____. The claimant

has been treated by Real Healthcare under the direction of John Randolph, D.C. whose treatment has consisted of chiropractic manipulation with various physiotherapy modalities and therapeutic exercises. The claimant had an MRI of the lumbar spine performed on 7/23/04, which revealed a large eccentric disc herniation at L3/L4 with marked stenosis on the left and encroaching on the left neural foramen. Paracentral disc protrusion noted at L1/L2 on the right with a mild disc bulge evident at L4/L5 with mild stenosis. Canal stenosis is noted in the L3/L4 and L4/L5 levels. The claimant was referred to Issan Shanti, M.D. on 7/26/04 for evaluation and treatment. Dr. Shanti recommended the claimant to continue physical therapy with Dr. Randolph as well as recommended lumbar epidural steroid injection, which was performed on 12/9/04.

Requested Service(s)

Office visits (99212), manual electrical stimulation (97032), manual therapy technique (97140), therapeutic exercises (97110) and ultrasound (97035) for dates of service 7/19/04 - 12/29/04

Decision

I disagree with the insurance carrier and find that office visits (99212), manual electrical stimulation (97032), ultrasound (97035), manual therapy technique (97140), and therapeutic exercises (97110) are reasonable and necessary for up to 6-8 weeks or 9/4/04 and further treatment beyond this time frame could be consider excessive.

I agree with the insurance carrier and find the office visits (99212), manual electrical stimulation (97032), ultrasound (97035), manual therapy technique (97140), and therapeutic exercises (97110) are not reasonable and necessary after 6-8 weeks of treatment or after 9/4/04 and further treatment beyond this time frame would be considered excessive.

Rationale/Basis for Decision

It is apparent that the claimant suffered a compensable injury when he slipped and fell backwards onto scaffolding while at work injuring his low back. The claimant has had approximately 44 treatment visits with Real Health Care including chiropractic manipulation with various physiotherapy modalities and therapeutic exercises. The claimant was also referred for pain management, which included lumbar epidural steroid injections and prescription medications. However, 44 chiropractic treatments for an apparent lumbar disc injury would be considered excessive based on The Official Disability Guidelines 10th Edition, which allows up to 18 chiropractic treatments with evidence of objective functional improvement over a 6-8 week period for a lumbar disc injury. The claimant did not show any evidence of objective functional improvements or subjective improvements based on the daily SOAP notes provided by Real Health Care. Therefore, it would seem excessive and not medically reasonable or necessary for continued chiropractic manipulations with the modality therapies mentioned above and active therapeutic exercises. I form this decision using the Official Disability Guidelines 10th Edition which is a guideline of specific conditions which uses a major source being the "Mercy Guidelines", the consensus document created by the American Chiropractic Association in conjunction with the Congress of State Chiropractic Associations, entitled Guidelines for Chiropractic Quality Assurance and Practice Parameters, Proceedings of the Mercy Center Consensus Conference.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to DWC via facsimile or U.S. Postal Service from the office of the IRO on this 7th day of September 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder