



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: Brad Burdin, D. C. 9502 Computer Dr. Suite 100 San Antonio, TX 78229	MDR Tracking No.: M5-05-3239-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Box 42	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the TWCC 60 form, Explanations of Benefits and CMS 1500's. Position summary states, "Treatments and therapies were consistent and within the scope of chiropractic practices. Documents are being presented to substantiate health care provided, to relieve the effects of the compensable injury, promote recovery and enhance the ability of the employee to return to or to retain employment."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the TWCC 60 form.

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)
8-27-04 – 12-3-04	CPT codes 98940, 99212, E0745	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$725.53
8-27-04 – 12-3-04	CPT codes 97140, G0283, 97035	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

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 prevail on the majority of the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$725.53.

Based on review of the disputed issues within the request, the 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 9-7-05 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.

HCPCS code E0230 was denied by the carrier as "G-this payment is reduced because the charge was included in another procedure." Per the 2002 MFG this service is not global to another service performed on that date. Texas Labor Code 413.011 (d) and Rule 133.304 (i) (1-4) place certain requirements on the Requestor when billing for services for which the Commission has not established a maximum allowable reimbursement. Per Rule 133.307(g)(3)(D), the Requestor is required to discuss, demonstrate and justify that the payment being sought is a fair and reasonable rate of reimbursement. The Requestor has not provided sample EOBs or other evidence that the fees billed are for similar treatment of injured individuals and that reflect the fee charged to and paid by other carriers. No reimbursement recommended.

CPT code 97140 on 9-1-04, 9-8-04, 9-9-04, 9-10-04, 9-14-04, 9-15-04, 11-10-04, 11-12-04, 11-17-04, 11-18-04 and 11-19-04, was denied as "F- Payment is reduced from the billed amount in accordance with TWCC Fee Guideline's" or no original EOB's were provided. No payment was made on these services. Recommend reimbursement according to the 2002 MFG of \$349.03 (\$31.73 X 11 DOS).

CPT code G0283 on 9-1-04, 9-8-04, 9-9-04, 9-10-04, 9-14-04 and 11-10-04 was denied as "F- Payment is reduced from the billed amount in accordance with TWCC Fee Guideline's" or no original EOB's were provided. No payment was made on these services. Recommend reimbursement according to the 2002 MFG of \$80.46 (\$13.41 X 6 DOS).

CPT code 97035 on 9-1-04, 9-8-04, 9-9-04, 9-10-04, 9-14-04 and 11-10-04 was denied as "F- Payment is reduced from the billed amount in accordance with TWCC Fee Guideline's" or no original EOB's were provided. No payment was made on these services. Recommend reimbursement according to the 2002 MFG of \$88.86 (\$14.81 X 6 DOS).

HCPCS code A4556 on 10-27-04 was denied by the carrier as "G-this payment is reduced because the charge was included in another procedure." Per the 2002 MFG this service is not global to another service performed on that date. Texas Labor Code 413.011 (d) and Rule 133.304 (i) (1-4) place certain requirements on the Requestor when billing for services for which the Commission has not established a maximum allowable reimbursement. Per Rule 133.307(g)(3)(D), the Requestor is required to discuss, demonstrate and justify that the payment being sought is a fair and reasonable rate of reimbursement. The Requestor has not provided sample EOBs or other evidence that the fees billed are for similar treatment of injured individuals and that reflect the fee charged to and paid by other carriers. No reimbursement recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 133.304 and 413.011 (d).

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 carrier must refund the amount of the IRO fee (\$460.00) to the requestor within 30-days of receipt of this 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 \$1,243.88. 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:

Authorized Signature

Typed Name

10-11-05

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.



Specialty Independent Review Organization, Inc.

September 21, 2005

TWCC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient:
TWCC #:
MDR Tracking #: M5-05-3239-01
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to Specialty IRO for independent review in accordance with TWCC Rule 133.308, which allows for medical dispute resolution by an IRO.

Specialty IRO has performed an independent review of the care rendered 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.

This case was reviewed by a licensed Chiropractor. The reviewer is on the TWCC ADL. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ was injured on ___ while working for the _____. The injury apparently occurred when he was team dragging an unconscious individual when he felt lower back pain. He further notes that he had to lift the patient onto a gurney causing further back pain. He went to Methodist hospital for treatment then he presented to the office of Conrad Kothmann, DC/Brad Burdin, DC on 8/27/05. The diagnosis was of a lumbar sprain/strain with concomitant facet syndrome. Passive and active therapies were performed. He was referred to David Hirsch, DO. An MRI was performed on 10/19/04 to the lumbar spine. This indicated small protrusion at L1/2, small left L4/5 paracentral disc protrusion with mild posterior displacement of the left L5 nerve root, left L5/S1 protrusion compressing the left anterior thecal sac and displacement of the left S1 nerve root. The neurodiagnostic testing of 10/26/04 indicates a radiculopathy at left S1. The PPE of 9/27/04 indicates light/medium PDL. James Hood, MD performed an RME on 12/20/04. His discussion indicates, "there is no evidence for the necessity of continuation of any active physical or chiropractic treatment." The FCE of 3/10/05 indicates the patient is at a heavy PDL. He was returned to work on 3/28/05 according to the TWCC 73's. He had apparently been off of work secondary to another claim.

RECORDS REVIEWED

Records were reviewed from the treating doctor/requestor and from the respondent. Records from the requestor/treating doctor include the following: 9/9/05 letter from Samuel Peralez, table of records sent, 8/27/04 report by Conrad Kothmann, DC, various TWCC 73's, notes from 9/14/04 through 08/05/05 by Brad Burdin, DC, daily treatment log from 8/30/04 through 02/23/05, neurodiagnostic testing of 10/26/04, 2/7/05-7/26/05 notes by David Hirsch, DO, rehab handwritten notes, FCE of 3/10/05, 9/27/04 PPE, IME report by James Hood, MD of 12/20/04, 1/24/05 addendum by Dr. Hood, OT script of 3/20/05, McKenzie script by Dr. Hirsch, three view lumbar series report of 8/30/04 and lumbar MRI of 3/7/05 and 10/19/04.

Records from the respondent include some of the above, in addition to the following: 9/14/05 letter from Robert Josey, various HICFA 1500's, various EOB's, request for reconsiderations of various dates, physical assessment of duty form for the and DME script of 8/27/04.

DISPUTED SERVICES

The disputed services include 99212, 97140, G0283, 97035, 98940 and E0745 from 8/27/04 through 12/3/04.

DECISION

The reviewer disagrees with the previous adverse determination on code 98940, 99212 and E0745.

The reviewer agrees with the previous adverse determination regarding all remaining services.

BASIS FOR THE DECISION

The reviewer indicates that based upon the records submitted for review there is no establishment of medical necessity for the continuation of passive therapies beyond eight weeks. Secondly, the usage of a muscle stimulation unit can be used at home making the usage of in office therapy not medically necessary. Chiropractic manipulation is a viable option for the treatment of lower back pain. Lastly, office visits are medically necessary to track the changes in the patient's response to treatment.

Continued E-stim, ultrasound and manual therapy techniques were not proven to be medically effective at this stage of treatment according to the American College of Occupational and Environmental Medicine Guidelines. An active rehabilitation protocol may have been considered to be effective for this patient.

Lastly, the reviewer indicates that Dr. Hood's report does not preclude the medical necessity of the treatment rendered prior to his December 2004 examination. He notes that future care is not medically necessary. It is the reviewer's understanding that this is in contravention to TWCC Advisories, which indicate that care cannot be prospectively denied.

REFERENCES

ACOEM Guidelines

Council of Chiropractic Physiological Therapeutics and Rehabilitation Guidelines

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that there is no known conflict between the reviewer, Specialty IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,

Wendy Perelli, CEO

CC: Specialty IRO Medical Director