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.: M5-05-3280-01
SCD Back and Joint Clinic, Ltd. 200 E. 24th Street, Suite B Bryan, Texas 77803	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
Box 11	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included TWCC 60 form, Explanations of Benefits, medical documentation and CMS 1500's. Position summary stated, "It is our position that these services were reasonable, necessary and related to the compensable injury. Appeal and follow up with the carrier have failed to resolve the dispute."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No position summary was 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)
10-27-04 – 4-14-05	CPT codes 99212, 99213, 98940, 97124, 97150, 97530, 97112, G0283, 97024, 97750, A4595	☐ Yes ☒ 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 disputed medical necessity issues.

In a letter dated 9-15-05 the requestor withdrew CPT code 97139-EU. These services will not be a part of this review.

On 9-8-05 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 CPT code 99080-73 on 12-6-04 and 4-6-05: The carrier denied this service with a "U" for unnecessary medical treatment; 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. The Medical Review Division has jurisdiction in this matter. Recommend reimbursement of $30.00 ($15.00 X DOS).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 129.5 and 133.308.

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 Division has determined that the requestor is not entitled to a refund of the IRO fee. The requestor is entitled to reimbursement in the amount of $30.00. 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 by:

		10-17-05
Authorized Signature	Typed Name	Date of Findings and Decision

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.

October 14, 2005
October 5, 2005

TDI, Division of Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-05-3280-01
TWCC#:
Injured Employee: ___
DOI: ___
SS#:
IRO Certificate No.: IRO 5055

Dear Ms. ___:

IRI has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc. and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in chiropractic, and is currently on the TWCC Approved Doctor List.

Your Right To Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). 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. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

Sincerely,

Gilbert Prud'homme
General Counsel

GP:dd

REVIEWER'S REPORT
M5-05-3280-01

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Information Provided for Review:
TWCC-60, Table of Disputed Services, EOB's
Information provided by Requestor:
- Correspondence
- Office Notes (08/05/04 – 01/19/05)
- Daily Progress Notes ((08/05/04 – 08/30/05)
- PT Notes (09/29/04 – 01/17/05)
- Functional Capacity Eval (08/05/04 – 01/10/05)
- Electro-diagnostic Eval (06/14/05)
- Radiology Report (10/29/04)

Orthopedics:
- Office Notes (07/28/04 – 08/31/05)
- OR Report (07/23/05)

Clinical History:
Patient underwent surgery and physical medicine treatments after sustaining injury at work on ___.

Disputed Services:
99212, 99213 office visits, 98940 chiropractic manipulation, 97124 massage, 97150 group therapy procedures, 97530 therapeutic activities, 97112 neuromuscular reeducation, G0283 electrical stimulation, 97024 diathermy, 97750 muscle testing, A4595 TENS supplies (not marked as "fee') and **99211 office visit, 99214 office visit**, from 10/27/04 through 04/14/05.

Decision:
The reviewer agrees with the determination of the insurance carrier and is of the opinion that the services in dispute as stated above were not medically necessary in this case.

Rationale:
Physical medicine is an accepted part of a rehabilitation program following surgery. 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) Home care programs should be initiated near the beginning of care, include ongoing assessments of compliance and result in fading treatment frequency. (B) 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. (C) Supporting documentation for additional treatment must be furnished when exceptional factors or extenuating circumstances are present. (D) 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 no evidence of a change of treatment plan to justify additional treatment in the absence of positive response to prior treatment. Moreover, the disputed services failed to fulfill statutory requirements 1 for medical necessity since the patient obtained no relief, promotion of recovery was not accomplished and there was no enhancement of the employee's ability to return to or retain employment. The patient's lack of response to previous treatment is evidenced by her pain ratings of 5/10 on 09/24/04 and 6/10 on 10/25/04. The patient's lack of response to the disputed treatment is evidenced by her pain ratings of 5/10 on 10/29/05 (near initiation) and 5/10 on 04/14/05 (at termination of the disputed treatment).

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1 Texas Labor Code 408.021