



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: <input checked="" type="checkbox"/> Health Care Provider <input type="checkbox"/> Injured Employee <input type="checkbox"/> Insurance Carrier	
Requestor's Name and Address: SCD Back & Joint Clinic, Ltd. 200 E. 24 th Street, Suite B Bryan, Texas 77803	MDR Tracking No.: M5-05-3283-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Liberty Mutual Fire Insurance Box 28	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: TWCC-60, CMS 1500s and explanations of benefits.
POSITION SUMMARY FROM TABLE OF DISPUTED SERVICES: Treatment was medically reasonable and necessary

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Explanations of benefits
POSITION SUMMARY: None submitted

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
09-28-04 to 03-03-05	99211, 99212-25, 99213-25, 97012, 98940, 98941, 97024, 97124, G0283, A4595 and A9150	<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 disputed medical necessity issues.

The requestor on 09-26-05 withdrew the fee issues within the dispute, therefore these issues will not be a part of the review.

CPT code 97139-EU listed on the table of disputed services was billed with an invalid modifier per the 2002 Medical Fee Guideline and will not be a part of the review.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 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 reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

10-03-05

Authorized Signature

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.

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

Phone: 512-402-1400

FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	
MDR Tracking Number:	M5-05-3283-01
Name of Patient:	
Name of URA/Payer:	SCD Back & Joint Clinic, Ltd.
Name of Provider: (ER, Hospital, or Other Facility)	SCD Back & Joint Clinic, Ltd.
Name of Physician: (Treating or Requesting)	John R. Wyatt, DC

September 28, 2005

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on the Division of Workers' Compensation Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Division of Workers' Compensation

CLINICAL HISTORY

Documents Reviewed Included the Following:

1. Correspondence, examination and treatment records from the provider
2. Correspondence from the carrier
3. Designated doctor report
4. Carrier reviews
5. Operative reports
6. EOBs
7. Reports from R. David Calvo, M.D. and Susan Herdman, PAC
8. Reports from Randall Light, M.D.
9. Reports from David Suchowiecky, M.D.
10. Diagnostic imaging reports

11. Report from Kenneth Berliner, M.D.
12. Report from Graciela Leon, L.P.C.

Claimant underwent extensive physical medicine treatments and ESI after sustaining injury on ____ when he fell backwards onto a stack of filled hard plastic containers hitting his head, lower back and upper back.

REQUESTED SERVICE(S)

Office visits 99211-25, 99212-25, 99213-25; mechanical traction 97012; chiropractic manipulative treatment 98940/98941; diathermy 97024; massage therapy 97124; electrical stimulation unattended G0283; TENS supplies A4595; and Biofreeze A9150 from 09/28/04 through 03/03/05.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

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. 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 subjective, objective or functional improvement in this patient's condition.

The *Guidelines for Chiropractic Quality Assurance and Practice Parameters* 1 Chapter 8 under "Failure to Meet Treatment/Care Objectives" states, "After a maximum of two trial therapy series of manual procedures lasting up to two weeks each (four weeks total) without significant documented improvement, manual procedures may no longer be appropriate and alternative care should be considered." The ACOEM Guidelines 2 state that if manipulation does not bring improvement in three to four weeks, it should be stopped and the patient reevaluated.

In this case, the claimant did not improve as evidenced by his pain ratings that were 4/10 on 12/18/03, 4/10 on 09/28/04 (at the initiation of the disputed treatment) and 6/10 on 03/03/05 (at the termination of the disputed treatment). Moreover, the disputed treatment was a continuation of the very same care that had been previously unsuccessful, as evidenced by the patient's decrease in lumbar, thoracic and cervical ranges of motion from 12/19/03 to 02/13/04 to 05/28/04.

To some degree, the claimant's lack of positive response was foreseeable since the ACOEM Guidelines 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.

And finally, the 04/22/04 report of the designated doctor – who carries presumptive weight – correctly stated, "He has received a full measure of conservative treatment for his cervical strain, and he has also received ample non-surgical treatment for his lumbar spine. And there is no strong argument in the medical record for further active diagnosis or treatment."

1 Haldeman, S; Chapman-Smith, D; Petersen, D *Guidelines for Chiropractic Quality Assurance and Practice Parameters*, Aspen Publishers, Inc.

2 ACOEM *Occupational Medicine Practice Guidelines: Evaluation and Management of Common Health Problems and Functional Recovery in Workers*, 2nd Edition.