



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:
Richard Stephenson, D.C.
322 N. Main Street
Bryan, Texas 77803

MDR Tracking No.: M5-05-3306-01

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: DWC-60 dispute package

POSITION SUMMARY: The carrier has not paid these claims due to a peer review finding that no further treatment is recommended. This is an invalid reason for denial of payment. On 02-10-05, the designated doctor found the patient to not be at MMI and to be in need for further care. The total billed for dates of service 03-01-05 to 04-04-05 was 2353.00 The total paid by the carrier for dates of service 03-01-05 to 04-04-05 was 406.80. The total unpaid portion is \$2,246.20 for dates of service 03-01-05 to 04-04-05. The total due by the carrier is \$2,246.20 according to the Texas Medical Fee Guidelines and the Medicare Guidelines.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60

POSITION SUMMARY: No position summary submitted by Respondent

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
03-01-05	99203	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$75.00
03-21-05 & 04-04-05	99213	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$100.00
03-01-05 to 04-01-05	97032, 97035, 97124, 97024, 97116, 97530 and 99213 (with the exceptions above)	<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 **prevailed** on the disputed medical necessity issues.

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 10-18-05, 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.

In regards to CPT code 99080-73 dates of service 03-21-05 and 03-29-05 the carrier submitted EOBs on 11-11-05 verifying payment of \$27.00 (\$13.50 for each date of service in dispute) and explanation code P303 (this service was reviewed in accordance with your contract). The Requestor did not provide information that a contract did not exist at the dates of service. No additional reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308

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 \$175.00. The Division finds that the requestor was the not prevailing party and is not entitled to a refund of the IRO fee. 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.

Ordered by:

Authorized Signature

12-14-05

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.

November 22, 2005

ATTN: Program Administrator
Texas Department of Insurance/Workers Compensation Division
7551 Metro Center Drive, Suite 100
Austin, TX 78744
Delivered by fax: 512.804.4868

Notice of Determination

MDR TRACKING NUMBER: M5-05-3306-01
RE: Independent review for ____

The independent review for the patient named above has been completed.

- Parker Healthcare Management received notification of independent review on 10.18.05.
- Faxed request for provider records made on 10.18.05.
- TDI-DWC issued an Order for records on 11.01.05.
- The case was assigned to a reviewer on 11.11.05.
- The reviewer rendered a determination on 11.21.05.
- The Notice of Determination was sent on 11.22.05.

The findings of the independent review are as follows:

Questions for Review

The therapy in question is referenced as 99203, 99213 (Office visits), 97032 (Electrical stimulation), 97035 (Ultrasound), 97124 (Massage), 97024 (Diathermy), 97116 (Gait training) and 97530 (Therapeutic Activities). All are reported as being denied for medical necessity. The dates of service that are listed in dispute are 3.01.05 thru 4.04.05. The date of injury is ____.

Determination

PHMO, Inc. has performed an independent review of the proposed care to determine if the adverse determination was appropriate. After review of all medical records received from both parties involved, the PHMO, Inc. physician reviewer has determined to **overturn the denial** on the denied services listed:

3.01.05- 99203
3.21.05- 99213
4.04.05- 99213

The PHMO, Inc. physician reviewer has also determined to **uphold the denial** on the rest of the denied services not specifically listed as being overturned.

Summary of Clinical History

The patient had an injury to the lower back and has received diagnostics including advanced imaging, EDX studies and various medical and chiropractic consultations. The claimant had an extensive amount of rehabilitative and conservative care, then had a mill lapse in therapy, then missed some therapy apparently and was discharged from Dr. Wyatt's care. The claimant then changes to Dr. Stephenson, as a new treating doctor and had more of the same type of care. Despite being way out of the acute and sub-acute phases of care, passive modalities were applied as a means of therapy. The claimant then had surgery (4.20.05) and post surgical care.

Clinical Rationale

It appears that the claimant had received rehabilitation and conservative care, changed treating doctors and then had basically a repeat of the same type of care with another doctor, including passive modalities. Surgery was performed on 4.20.05; the care given by Dr. Stephenson was given from the dates of 3.01.05 up until 4.04.05, which is right before the surgery was performed. It appears that this care made little to no change in regards to pain and the claimant had very little objective improvement noted during this time. This was essentially a repeat of conservative therapy that had already failed. There is no documentation that clearly demonstrates that, as a result of the given care in question, that there was any noticed symptom relieving effects, curative effects or increasing to the point of returning back to gainful employment. It ultimately boiled down to the need for surgery in order to make the appropriate corrections. Care after surgery is anticipated, but a repeat of conservative care a second time before the surgery, including passive modalities and despite past failures is not supported as a necessary form of care. The office visits are necessary because the treating doctor is obligated to monitor the claimant as therapy is provided or referrals are made. As a result of having to manage the claimants care, office visits on occasion, every 15 to 30 days, is essential. Having said this, out of the multiple visits it appears that approximately 3 of those visits would warrant the need for an office visit to monitor the claimant at the appropriately spaced out intervals.

Clinical Criteria, Utilization Guidelines or other material referenced

- *Occupational Medicine Practice Guidelines*, Second Edition.
 - *The Medical Disability Advisor*, Presley Reed MD
 - *A Doctors Guide to Record Keeping*, Utilization Management and Review, Gregg Fisher
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The reviewer for this case is a doctor of chiropractic peer matched with the provider that rendered the care in dispute. The reviewer is engaged in the practice of chiropractic on a full-time basis.

The review was performed in accordance with Texas Insurance Code 21.58C and the rules of Texas Department of Insurance /Division of Workers' Compensation. In accordance with the act and the rules, the review is listed on the DWC's list of approved providers or has a temporary exemption. The review includes the determination and the clinical rationale to support the determination. Specific utilization review criteria or other treatment guidelines used in this review are referenced.

The reviewer signed a certification attesting that no known conflicts-of-interest exist between the reviewer and any of the providers, the injured employee, injured employee's insurance carrier, the URA or any other parties associated with this case. The reviewer also attests that the review was performed without any bias for or against the patient, carrier, or other parties associated with this case.

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. The address for the Chief Clerk of Proceedings would be: P.O. Box 17787, Austin, and Texas, 78744.

I hereby verify that a copy of this Findings and Decision was faxed to Texas Department of Insurance /Division of Workers Compensation applicable to Commission Rule 102.5 this 22nd day of November 2005. The Division of Workers Compensation will forward the determination to all parties involved in the case including the requestor, respondent and the injured worker.

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.