



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.: M5-06-0027-01
Pain & Recovery Clinic, c/o Bose Consulting LLC PO Box 550496 Houston TX 77255	Claim No.:
	Injured Worker's Name:
Respondent's Name and Address:	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:
Lumberman's Mutual Ins Box 42	

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DWC-60 package, EOBs, CMS-1500s. Position summary: Treatment provided to the patient has been medically reasonable and necessary based on accepted medical protocols and Texas Labor Code.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No response submitted.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
11-10-04 to 2-28-05	99212, 97035, 97110, 97112, 97018, 97032, 97116, 97140, 97124, 97750, E1399	<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.

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 9-29-05, Medical Review 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.

On 9-28-05, the requestor notified Medical Review that all office visits listed on the table of disputed services had been paid.

Code 99080 listed on the table of disputed services for dates 12-10-04 and 1-12-05 had no EOB submitted by either party. The requestor did not submit CMS-1500s for these two dates of service. The requestor submitted additional documentation as required by Rule 133.307; however, no DWC-73 report was included for these two dates of service. Therefore, service cannot be verified. No reimbursement recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 133.307, 134.202

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 additional reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

Medical Dispute Officer

11-15-05

Authorized Signature

Typed Name

Date

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.

P-IRO

An Independent Review Organization
7626 Parkview Circle
Austin, Texas 78731

Phone: 512-346-5040

Fax: 512-692-2924

November 4, 2005

TDI-DWC Medical Dispute Resolution
Fax: (512) 804-4868

Delivered via Fax

Patient / Injured Employee _____
TDI-DWC # _____
MDR Tracking #: M5-06-0027-01
IRO #: 5312

P-IRO, Inc. has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI-Division of Worker's Compensation (DWC) has assigned this case to P-IRO for independent review in accordance with DWC Rule 133.308 which allows for medical dispute resolution by an IRO.

P-IRO has performed an independent review of the proposed care 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.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Provider board certified and specialized in Chiropractic Care. The reviewer is on the DWC Approved Doctor List (ADL). The P-IRO Panel Member/Reviewer is a health care professional who has signed a certification statement stating that no known conflicts of interest exist between the Reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carriers health care providers who reviewed the case for decision before referral to IRO America for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

RECORDS REVIEWED

Notification of IRO assignment, information provided by The Requestor, Respondent, and Treating Doctor(s), including:

1. Physician's statement from Bose Consulting.
2. Records from Marcus Masson, M.D.
3. Operative report from Twelve Oaks Medical Center dated 05/31/05 from Marcus Masson, M.D.
4. Initial comprehensive evaluation from Pain Management Consultants dated 07/22/04.
5. Records from Andrew McKay, M.D.
6. Records from Pain and Recovery Clinics of Houston.
7. Daily treatment notes from Pain and Recovery Clinics of Houston.
8. Table of disputed services.
9. Initial medical report from the Pain and Recovery Clinics of Houston dated 07/21/04.
10. Followup notes and subsequent medical reports from the Pain and Recovery Clinics of Houston.

CLINICAL HISTORY

Mr. ___ suffered an on-the-job injury while working for _____ on ____. The Patient was working with sheet metal that apparently cut through his glove, which caused a laceration to his left index finger.

The Patient was taken to the emergency room. Sutures were placed. The Patient followed up with a plastic surgeon. The Patient was taking multiple medications to assist with his discomfort.

The Patient presented to Pain and Recovery Clinics of Houston on 07/21/04, where at which time he was evaluated by a chiropractor with a diagnosis of second digit left hand arthralgia and left hand neuropathy. The chiropractor recommended a consultation with Dr. Varon who also recommended a course of chiropractic treatment and physical rehabilitation.

The Patient underwent extensive amounts of treatment at Pain and Recovery Clinics of Houston. The Patient went on to undergo operative procedure on 05/31/05 by Marcus Masson, M.D. to include a left index finger radial digit nerve single cable graft as well as a left index finger ulnar digital nerve neurolysis and exploration.

The table of disputed services includes services extending from 11/10/04 through 02/28/05. Treatment includes the following, 99212 office visit, ultrasound 97035, therapeutic exercises 97110 times three to four units, neuromuscular re-education 97112 times two units, paraffin bath 97018, electric muscle stimulation 97032, gait training 97116, manual therapy techniques 97140, as well as massage therapy 97124, as well as a PPE 97750.

DISPUTED SERVICE (S)

Under dispute is the Retrospective medical necessity of Office Visit – 99212, ultrasound, 97035, therapeutic exercises – 97110, neuromuscular re-education – 97112, paraffin bath – 97018, electrical stimulation (manual) – 97032, gait training – 97116, DME E1399, Manual therapy technique – 97140, Massage therapy – 97124 and physical performance test – 97750. Do not review items on table inducted to be fee issues. DOS: 11-10-04 thru 2-28-05.

DETERMINATION / DECISION

The Reviewer agrees with the determination of the insurance carrier.

RATIONALE/BASIS FOR THE DECISION

It is The Reviewer's opinion that the disputed services from the provider are not medically necessary for the following reasons: After review of the records from Pain and Recovery Clinics of Houston, the rationale in the physician's statement dispute from Bose Consulting regarding the services performed at Pain and Recovery Clinics is based on the necessity for post injection therapy following epidural injections from Spine 2002. This states that "A longer duration effect when combined with structural rehabilitation, reduces the time to maximum medical improvement, reduces the need for a series of injections by protocol, is more psychologically sound, reduces morbidity, may improve return to work, and may reduce need for surgical intervention." Clearly, this Patient did not undergo an epidural steroid injection. This patient underwent injections for a laceration to the index finger and subsequent symptoms associated with this injury. To base a rationale for medical necessity on an epidural steroid injection makes no sense whatsoever and is void of any logic or rational thought.

Services including 97110 therapeutic exercises times up to three to four units is not medically necessary and the daily clinical records do not support the medical necessity of one-on-one supervised exercises for 45 minutes to 1 hour.

There are no exercise logs provided, nor is there any specific documentation regarding the frequency, duration, or intensity of exercises performed to support this service. Please keep in mind that the extent of injury here is a laceration to the index finger, how one would require up to one hour of therapeutic exercises and 45 minutes of neuromuscular reeducation is beyond me. Regarding the billing of 97112 times multiple units, which is billed as neuromuscular re-education, once again the clinical records do not support the medical necessity of multiple units of 97112 in this case and the clinical records also do not support the performance of this level of service. The passive modalities performed including massage therapy, paraffin bath, and electrical muscle stimulation, which were performed greater than one year post injury are not medically necessary and the contemporary clinical literature does not support the need for passive modalities for upper extremity injuries greater than 8 weeks post injury.

Regarding the performance of gait training billed as 97032, Please inform this reviewer as to why one would require gait training for a laceration of the ring finger. This service is absolutely not indicated. The physical performance test billed as 97750 is also deemed not to be medically necessary.

Screening Criteria

1. General:

In making his determination, the Reviewer had reviewed medically acceptable screening criteria relevant to the case, which may include but is not limited to any of the following: Evidence Based Medicine Guidelines (Helsinki, Finland); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Texas Chiropractic Association: Texas Guidelines to Quality Assurance (Austin Texas); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Mercy Center Guidelines of Quality Assurance; any and all guidelines issued by DWC or other State of Texas Agencies; standards contained in Medicare Coverage Database; ACOEM Guidelines; peer-reviewed literate and scientific studies that meet nationally recognized standards; standard references compendia; and findings; studies conducted under the auspices of federal government agencies and research institutes; the findings of any national board recognized by the National Institutes of Health; peer reviewed abstracts submitted for presentation at major medical associates meetings; any other recognized authorities and systems of evaluation that are relevant.

CERTIFICATION BY OFFICER

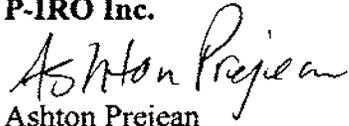
P-IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. P-IRO has made no determinations regarding benefits available under the injured employee's policy.

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

P-IRO is forwarding by mail or facsimile, a copy of this finding to the DWC, the Injured Employee, the Respondent, the Requestor, and the Treating Doctor.

Sincerely,

P-IRO Inc.



Ashton Prejean

President & Chief Resolutions Officer