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.: M5-06-0036-01
Richard Stephenson DC **322 North Main Street** **Bryan TX 77803**	Claim No.:
	Injured Worker's Name:
Respondent's Name and Address: **Box 45**	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documentation submitted: Medical Dispute Resolution Request package, EOBs, CMS-1500s. The treatment consisting of chiropractic management and adjunctive therapy modalities consisting of ultrasound,. Attended electric muscle stimulation, and massage. The treatment is in accordance with the TWCC Spine Treatment Guidelines and Medicare Guidelines.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Office will maintain its denials as stated.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
3-8-05 to 3-29-05	97035	☐ Yes ☒ No	$ 0.00
	99213 $50.00 x 7 days	☒ Yes ☐ No	$350.00

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.

Code 97032 billed on dates of service 3-8-05 to 3-29-05 (8 days) was denied as 510, payment determined and W1,Workers' Compensation State Fee Schedule Adj.". The carrier paid one unit. Carrier states that reasonable and necessary was paid for code 97032 in regards to the utilization guidelines of Medicare's physical medicine and rehab that the usual treatment session provided in home or office session is 30-45 minutes. 97032 is billed in 15-minute increments and the requestor billed two units. This equals 30 minutes per session. Therefore, recommend additional reimbursement of $7.82 x 8 days - $

62.56.
Code 97530 billed on date of service 3-29-05 was denied as '510 – payment determined' and W1 – Workers' Compensation State Fee Schedule Adj.". The carrier paid for one unit. The carrier had no additional response. The requestor billed two units; therefore, recommend additional reimbursement of $35.15.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 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 entitled to additional reimbursement in the amount of $447.71. In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of $460.00. 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:

	Medical Dispute Officer	11-2-05
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.

PROFESSIONAL ASSOCIATES

NOTICE OF INDEPENDENT REVIEW

NAME OF PATIENT:
IRO CASE NUMBER: M5-06-0036-01
NAME OF REQUESTOR: Richard Stephenson, D.C.
NAME OF PROVIDER: Richard Stephenson, D.C.
REVIEWED BY: Licensed by The Texas State Board of Chiropractic Examiners
IRO CERTIFICATION NO: IRO 5288
DATE OF REPORT: 10/14/05 (REVISED10/21/05)
(REVISED 11/11/05)

Dear Dr. Stephenson:

Professional Associates has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO) (#IRO5288). Texas Insurance Code Article 21.58C, effective September 1, 1997, allows a patient, in the event of a life-threatening condition or after having completed the utilization review agent's internal process, to appeal an adverse determination by requesting an independent review by an IRO.

In accordance with the requirement for TDI-Division of Workers' Compensation (DWC) to randomly assign cases to IROs, DWC has assigned your case to Professional Associates for an independent review. The reviewing physician selected has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, the reviewing physician reviewed relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal. determination, and any documentation and written information submitted in support of the appeal.

This case was reviewed by a physician reviewer who is Licensed by the Texas Board of Chiropractic Examiners and is currently listed on the DWC Approved Doctor List.

I am the Secretary and General Counsel of Professional Associates and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts interest that exist between him the provider, 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 carrier health care providers who reviewed the case for decision before referral to the Independent Review Organization.

REVIEWER REPORT

Information Provided for Review:

Evaluations with Mark Yezak, D.C. dated 11/08/04, 11/17/04, 12/02/04, and 12/14/04
A physical therapy evaluation with A. Anthony Child, M.P.T. dated 11/09/04
Physical therapy with Kathy Martz, L.P.A. and Vickie Noack, P.T. on 11/10/04, 11/11/04, 11/17/04, and 11/18/04
A Functional Capacity Evaluation (FCE) with Karen Seade, L.P.T. dated 01/26/05
A TWCC-69 form by Dr. Yezak dated 02/16/05
A TWCC-53 form, a request to change treating physicians, dated 03/03/05
An evaluation with Richard J. Stephenson, D.C. dated 03/08/05

Therapy sessions with Dr. Stephenson on 03/11/05, 03/14/05, 03/15/05, 03/18/05, 03/21/05, 03/23/05, 03/25/05, and 03/29/05
A letter of referral from Dr. Stephenson on 03/14/05
An attending physician's statement from Dr. Stephenson on 03/18/05
A request for reconsideration from Dr. Stephenson on 03/30/05
A letter written to the patient from Dr. Stephenson on 04/06/05
A Designated Doctor Evaluation by Marcy Halterman, D.C. dated 04/19/05
A letter of discharge from Dr. Stephenson dated 04/19/05
An EMG/NCV study interpreted by Jarrod M. Cashion, D.C. dated 04/25/05
A request for change of treating physician dated 04/28/05 from Dr. Johnson
Another TWCC-53 form dated 05/11/05

Clinical History Summarized:

Dr. Yezak recommended a course of physical therapy, x-rays of the right shoulder, and medication therapy as of 11/08/04. Physical therapy was performed with Ms. Martz and Ms. Noack on 11/10/04, 11/11/04, 11/17/04, and 11/18/04. A Functional Capacity Evaluation (FCE) with Ms. Seade on 01/26/05 showed the patient was at the light physical demand level and would benefit from a work conditioning program. On 02/16/05, Dr. Yezak placed the patient at Maximum Medical Improvement (MMI) with a 0% whole person impairment rating. On 03/08/05, Dr. Stephenson recommended chiropractic treatment, a possible MRI, and an orthopedic evaluation. Therapy was performed with Dr. Stephenson from 03/11/05 through 03/29/05 for a total of eight sessions. On 03/30/05, Dr. Stephenson wrote a request for reconsideration for an MRI of the right shoulder and orthopedic evaluation. Dr. Halterman felt the patient was not at MMI on 04/19/05 and recommended a work conditioning program. On 04/19/05, Dr. Stephenson noted the patient was discharged from his care on 04/13/05 due to multiple missed appointments. An EMG/NCV study interpreted by Dr. Cashion revealed a possible preexisting nerve lesion of the left median nerve. The patient changed treating physicians from Dr. Stephenson to Dr. Johnson on 05/11/05.

Disputed Services:

Ultrasound treatments and office visits from 03/08/05 through 03/29/05

Decision:

I partially disagree with the requestor. The ultrasound treatments from 03/08/05 through 03/29/05 were not reasonable or necessary. However, the office visits from 03/08/05 through 03/29/05 were reasonable and necessary.

Rationale/Basis for Decision:

After reviewing the medical records provided, it was found that the ultrasound treatment from 03/08/05 through 03/29/05 were not medically necessary to treat this patient. The North American Spine Society *Guidelines for Multidisciplinary Spine Care Specialist, 2002*, stated that after 16 weeks from the date of injury, an injured person has reached the tertiary phase of treatment. Tertiary phase interventions include chronic pain management, functional restoration, pharmacological treatment, behavior techniques, epidural steroid injections (ESIs), and other types of therapeutic injections. In short, the ultrasound treatments that were performed from 03/08/05 to 03/29/05 were performed in the tertiary phase of care, but did not allow for continued passive modalities, of which ultrasound treatments are considered.

In regard to the office visits from 03/08/05 through 03/29/05, the North American Spine Society *Guidelines for Multidisciplinary Spine Care,* states*Speicalist, 2002,* states that a history, physical examination, and treatment outcomes are necessary to document the effectiveness of treatment. The office visits from 03/08/05 through 03/29/05 not only provided the history, physical examination, and treatment outcomes, but contained the examination and maintenance defined by the Center for Medicare and Medicaid. Therefore, the office visits were medically necessary to treat the claimant.

This review was conducted on the basis of medical and administrative records provided with the assumption that the material is true and correct.

This decision by the reviewing physician consulting for Professional Associates is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

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. A request for a hearing should be faxed to 512-804-4011 or sent to:

Chief Clerk of Proceedings/Appeals Clerk
TDI-Division of Workers' Compensation
P. O. Box 17787
Austin, TX 78744

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for
hearing to all other parties involved in the dispute

I hereby verify that a copy of this Independent Review Organization's decision was sent to DWC via facsimile or U.S. Postal Service on 11/11/05/05 from the office of Professional Associates.

Sincerely,

_____
Lisa Christian
Secretary/General Counsel