



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

Requestors Name and Address: SCD Back and Joint Clinic, Ltd. 200 E. 24 th Street, Suite B Bryan, Texas 77803	MDR Tracking No.: M5-06-0071-01
	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

Documents included DWC 60 package. Position summary states, "After receiving our submission, the carrier chose to disregard pages 48 – 55 where the HCFAs for DOS 10-27-04 -11-8-04 were located....The carrier continued to deny care beyond the November review despite the fact that the reviewer did not actually review additional DOS or documentation."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response. No position summary was received.

PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

<u>Date(s) of Service</u>	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
9-21-04 – 1-18-05	CPT codes 99211, 99213, 97012, 98940, 98943, 97024, 97124, 97112, 97018, 97530, 95851, 97150, 97110, G0283, 97750, A4596	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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 medical necessity issues.

Based on review of the disputed issues within the request, the 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 9-27-05 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.

Rule 134.202 (b) states that Texas Workers' Compensation system participants shall apply the Medicare program reimbursement coding, billing, and reporting payment policies in effect on the date a service is provided. Rule 133.1(a)(3)(C) states that a complete medical bill includes correct billing codes from Division fee guidelines in effect on the date of service. The requestor billed code 97139-EU. Per Rule 134.202 (b) These modifiers are invalid with these codes after 8-1-03; therefore, no review and no reimbursement recommended.

In a letter dated 10-28-05 the requestor withdrew CPT Code 99080-73 for dates of service 12-17-04 and 1-6-05. These services will not be a part of this review.

CPT code 99080-73 date of service 01-07-05 denied with denial code "V" (based on peer review further treatment is not recommended). The IRO reviewer concluded that the office visit (99212-25) on date of service 01-07-05 was not medically necessary. Based on Rule 133.308(p)(5) An IRO decision is deemed to be a Division decision and order, therefore no reimbursement is recommended for code 99080-73 either.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 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 and Order by:

Donna Auby

3-15-06

Authorized Signature

Typed Name

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.

October 18, 2005

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

Re: Medical Dispute Resolution
MDR #: M5-06-0071-01
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 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.

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 licensed in chiropractic, and is currently on the DWC 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
M5-06-0071-01

Information Provided for Review:

DWC-60, Table of Disputed Services, EOB's

Information provided by Requestor:

- Correspondence
- Office Notes 08/10/04 – 01/20/05
- Daily Progress Notes 08/10/04 – 06/07/05
- PT Notes 08/19/04 – 01/14/05
- Range of Motion Tests 09/21/04 – 12/08/04
- Conduction Test 10/11/04
- Radiology 09/09/04

Information provided by Respondent:

Pain Management:

- Office Visit 09/08/04

Orthopedics:

- Office Visit 01/26/05

Clinical History:

Patient underwent extensive physical medicine treatments after reporting a work related repetitive motion injury on ____.

Disputed Services:

Office visits 99211 and 99213, mechanical traction 97012; chiropractic manipulative treatment 98940 and 98943; diathermy 97024; massage therapy 97124; neuromuscular reeducation 97112, paraffin baths 97018, therapeutic activities 97530, range of motion testing 95851, group therapeutic procedures 97150, therapeutic exercises 97110, electrical stimulation G0283; muscle testing 97750, and TENS supplies A4595 from 09/21/04 through 01/18/05.

Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion the services in dispute were not medically necessary in this case.

Rationale:

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 Guidelines² state that if manipulation does not bring improvement in three to four weeks, it should be discontinued. Therefore, there was support for the initial 4 weeks of treatment from 08/16/04 through 09/16/04.

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

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.

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. There is no support for continuing unsuccessful treatment after the initial 4-week period since the claimant's pain rating was 6/10 at the initiation of treatment on 08/16/04 and remained at 6/10 on 09/16/04. The claimant's lack of response to the disputed treatment is documented by the ROM examinations performed on 09/21/04 and 10/14/04 that show no improvement in most planes. Moreover, the patient's pain rating remained as high as 5/10 as late as 12/23/04. Therefore, the disputed services failed to fulfill statutory requirements³ 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.

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.

³ Texas Labor Code 408.021