



MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address: Michael T. Fleck, D.C. 150 West Gibson Jasper, Texas 75951	MDR Tracking No.: M5-06-0115-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Church Mutual Insurance Company Box 17	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: Per table of disputed services "Treatment was medically necessary".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60
POSITION SUMMARY: In conclusion, there simply is no medical documentation to substantiate the medical necessity for the treatments provided by Requestor and they should not be entitled to any reimbursement.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
09-07-04 to 10-08-04 and 11-11-04 to 11-18-04	99214, 97140, 97032, 97035, 98941, 97140, 97012, 95851, 99212, G0283, 97110 and 97039	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
09-28-04	97750-FC	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$668.20
10-12-04 to 10-29-04	98941, 97110 and 99211	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$783.58

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 **majority** of the disputed medical necessity issues.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and Rule 134.202(c)(1)

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 \$1,451.78. The Division finds that the requestor was not the 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:

12-15-05

Authorized Signature

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.



CompPartners Final Report ACCREDITED EXTERNAL REVIEW

CompPartners Peer Review Network
Physician Review Recommendation
Prepared for TDI/DWC

Claimant Name:

Texas IRO # :

MDR #: M5-06-0115-01

Treating Provider: Michael Fleck, D.C.

Review: Chart

State: TX

Amended: 12/13/05

Review Data:

- Notification of IRO Assignment dated 9/30/05, 1 page.
- Receipt of Request dated 9/30/05, 1 page.

- **Medical Dispute Resolutions Request dated 9/8/05, 2 pages.**
- **Provider Federal Tax Identification Number and the License/Certification/Registration Number Request Form, 2 pages.**
- **Table of Disputed Services dated 9/7/04 through 11/18/04, 5 pages.**
- **Report of Medical Evaluation dated 3/29/05, 2/6/04, 2 pages.**
- **Account/Invoice dated 2/14/05, 12/21/04, 12/2/04, 11/11/04, 11/1/04, 10/22/04, 10/18/04, 10/7/04, 10/5/04, 9/23/04, 18 pages.**
- **Position Statement dated 10/21/05, 1 page.**
- **Prescription Authorization Request dated 8/26/04, 1 page.**
- **Letter of Enclosed Documents dated 10/5/05, 2 pages.**
- **Retrospective Medical Records Review dated 9/8/04, 3 pages.**
- **Designated Doctor Evaluation Reports dated 3/29/05, 12/6/04, 18 pages.**
- **Lumbar Spine MRI Report dated 6/4/04, 2 pages.**
- **History and Physical Report dated 6/10/04, 2 pages.**
- **Operative Reports dated 8/19/04, 6/24/04, 5 pages.**
- **SOAP Notes Re-exam dated 9/7/04, 3 pages.**
- **SOAP Note dated 9/9/04, 9/10/04, 9/14/04, 9/16/04, 9/21/04, 9/22/04, 9/24/04, 14 pages.**
- **Functional Assessment Report dated 9/28/04, 14 pages.**
- **Prescription Authorization Request dated 8/26/04, 1 page.**
- **SOAP Notes dated 9/30/04, 10/01/04, 10/5/04, 10/8/04, 10/12/04, 10/14/05, 10/15/04, 10/19/04, 10/26/04, 10/28/04, 10/29/04, 11/9/04, 11/11/04, 11/12/04, 11/18/04, 63 pages.**

Reason for Assignment by TDI/DWC: Determine the medical necessity for the previously denied ultrasound, office visits, electrical stimulation (manual), mechanical traction, manual therapy technique, chiropractic manipulative treatment, range of motion measurements (extremity/trunk), Functional Capacity Examination (FCE), electrical stimulation (unattended), unlisted modality and therapeutic exercises, with dates of service 9/7/04 through 11/18/04.

Determination: PARTIAL –

UPHELD – treatments for dates of service 9/7/04 through 10/8/04; 11/11/04, 11/12/04 and 11/18/04.

REVERSED – 7 visits for dates of service 10/12/04 through 10/29/04; and FCE performed on 9/28/04.

Rationale:

Patient's age: 51 years

Gender: Male

Date of Injury:

Mechanism of Injury: Moving new and old furniture, boxes of books, and church windows when he developed lower back pain radiating into the thighs and along with bilateral hip pain.

Diagnoses: lumbosacral neuritis/radiculitis, muscle spasm, nonallopathic lesion of the lumbar spine.

The patient was moving furniture and boxes on ____ in which he injured his lower back. Approximately one month later, on ____/11/2004, the claimant presented to the office of Dr. Fleck, D.C. An evaluation was performed and a course of physical therapy was initiated. According to a peer review report dated 9/8/2004 from Dr. Lening, the claimant received a total of 13 treatments from 5/11/2004 through 6/8/2004. The records for these dates of service were not submitted. On 6/4/2004, the claimant underwent an MRI of the lumbar spine. The findings were a 1-2 mm symmetric annular bulge and small inferior endplate T12 Schmorl's node and disc narrowing at T12-L1. At L3-4, there was a 2-3 mm left posterocentral protrusion. At L4-5, there was a 4-5 mm left lateral recess disc protrusion. On 6/10/2004, the claimant presented to the office of Dr. Uday Doctor, M.D. The claimant was diagnosed with lumbar discogenic and radicular pain. A recommendation for a transforaminal epidural steroid injection at L4-5 was submitted. On 6/24/2005, the claimant received the L4-5 transforaminal epidural steroid injection. This resulted in about a 50-60% improvement. A recommendation for a second ESI was submitted. On 8/19/2004, the claimant received the second L4-5 transforaminal epidural steroid injection. The 9/2/2004 progress notes from Dr. Doctor indicated that the

claimant did not receive any improvement from this procedure. The claimant was referred back to Dr. Fleck for continued physical therapy. There was also a recommendation for a discogram from L3 through S1 with a post CT scan. On 8/26/2004, Dr. Doctor provided a prescription for physical therapy at three times per week for four weeks, consisting of active exercise therapy. From 9/7/2004 through 11/18/2004, the claimant received a total of 22 additional treatments. On 9/28/2004, the claimant underwent a functional capacity evaluation under the direction of Dr. Fleck. As a result, a recommendation for an active rehabilitation program was submitted.

On 12/6/2004, the claimant underwent a designated doctor examination with Dr. Kumar-Misir, M.D. The determination was that the claimant was not at maximum medical improvement. A subsequent designated doctor examination was performed on 3/29/2005 by the same provider. A functional capacity evaluation was performed as a component of the designated doctor evaluation. The evaluator determined that the claimant had achieved clinical maximum medical improvement with 5% whole body impairment.

On 9/8/2004 a peer review was performed by Dr. Lening, D.C. The determination at that time was that continued chiropractic treatment was not appropriate. The purpose of this review is to determine the medical necessity for treatment for dates of service 9/7/2004 through 11/18/2004.

From 9/7/2004 through 10/8/2004 the claimant received 12 treatments consisting of chiropractic spinal manipulation and passive physiotherapy modalities. From 10/12/2004 through 11/18/2004 the claimant received a total of 10 treatments consisting of chiropractic spinal manipulation and therapeutic exercises. The medical necessity for the 12 treatments from 9/7/2004 through 10/8/2004 was not established. At that time, the claimant was five months post injury, and well past the stage where continued delivery of passive therapy could be considered appropriate. In fact, the prescription from Dr. Doctor was for active exercises and not a continued delivery of passive therapy only. When the claimant presented to the provider's office on 9/10/2004, his pain levels were noted at 3 out of 10 on the visual analogue scale. By 9/24/2004, the claimant's pain levels were noted at 1 out of 10 on the visual analogue scale. The claimant's pain levels fluctuated between 1-3 out of 10 through 10/8/2004. On 10/8/2004, the claimant's pain level was noted at 2 out of 10. A pain level of 3 out of 10 on the visual analogue scale equates to minimal to mild pain level. A delivery of passive treatment with this level of pain complaint is inappropriate and not supported by ACOEM Guidelines, Chapter 12, or Texas Medical Fee guidelines or the referral from Dr. Doctor.

A functional capacity evaluation was performed on 9/28/2004. It was noted that the claimant exhibited a decreased range of motion and abnormal biomechanics of the lumbar region. The evaluation also demonstrated weakness in the major muscle groups of the lumbar, as well as abdominal region. A recommendation for a rehabilitation program was submitted. Beginning 10/12/2004, the claimant began an exercise program. According to the 10/12/2004 SOAP notes, the claimant underwent therapeutic exercises and stretches for a total of 35 minutes. The claimant received similar treatment for the remainder of treatment through 11/18/2005. A review of the 11/18/2004 SOAP notes revealed a recommendation for continued therapy at three times per week. However, the 11/18/2004 treatment was the last treatment this claimant received. The medical necessity for the seven treatments for dates of service 10/12/2004 through 10/29/2004 was established. Given the functional deficits as noted on the functional capacity evaluation, a brief course of therapeutic exercises, to strengthen the claimant's trunk musculature, was appropriate. Over this three week period of time, the claimant received sufficient experience with the necessary stretches and exercises that he should have been transitioned to a self-directed home exercise program. Therefore, consistent with ACOEM Guidelines, Chapter 12 and Texas Medical Fee Guidelines, the medical necessity for the seven treatments consisting of chiropractic spinal manipulation and therapeutic exercises for dates of service 10/12/2004 through 10/29/2004 can be considered medically necessary and appropriate.

Criteria/Guidelines utilized: TDI/DWC rules and regulations.

ACOEM Guidelines, 2nd Edition, Chapter 12.

Texas Medical Fee guidelines.

Physician Reviewers Specialty: Chiropractic

Physician Reviewers Qualifications: Texas licensed DC, and is also currently listed on the TDI/DWC ADL list.

CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist between that provider 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 the decision before the referral to CompPartners, Inc.

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.