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: Southeast Health Services P. O. Box 453062 Garland, Texas 75045	MDR Tracking No.: M5-06-0532-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Dallas ISD, Box 42	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include DWC 60 package. Position summary lists the disputed CPT codes and the reasons each was necessary.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No response was received.

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

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
1-21-05 – 03-4-05	CPT code 99214	☒ Yes ☐ No	$107.01
1-21-05 – 03-4-05	CPT code 97035 ($15.59 X 5 DOS)	☒ Yes ☐ No	$77.95
1-21-05 – 03-4-05	CPT code 97113	☒ Yes ☐ No	$41.70
1-21-05 – 03-4-05	CPT code 97750-FC ($38.65 X 12 units)	☒ Yes ☐ No	$463.80
1-21-05 – 03-4-05	CPT code 93799 – see below	☒ Yes ☐ No	$122.00
1-21-05 – 02-4-05	CPT code 97032 – not disputed during this period	☐ Yes ☐ No	0
2-18-05	CPT code 97032	☐ Yes ☒ 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 prevail on the majority of the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is $812.46.

Texas Labor Code 413.011 (d) and Rule 133.304 (i) (1-4) places certain requirements on the Carrier when reducing the

services for which the Commission has not established a maximum allowable reimbursement. The Carrier is required to develop and consistently apply a methodology to determine fair and reasonable reimbursement and explain and document the method used for the calculation. The Carrier in this case has not provided a methodology as required by the rule. Recommend reimbursement as billed.

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 12-22-05 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.

HCPC code A4556 on 1-21-05 was denied by the carrier as "G-90-Included in Global." Per 2002 MFG, A4556 is a bundled code. This HCPCS code will not be reimbursed separately.

CPT code 99354-25 on 1-25-05 was denied by the carrier as "G-90-Included in Global." Per the 2002 MFG, this code is not included in the procedure of another service performed on this date. Per the 2002 MFG, "Prolonged physician services are add-on services and should be listed separately in addition to the E/M service." This code was listed in addition to the 99211 office visit performed on this date. Recommend reimbursement of $127.49.

CPT code 99080-73 was denied by the carrier as "U-Unnecessary medial treatment." The Evaluation and Management service performed on this date was medically necessary. Therefore the DWC 73 report issued on this date was necessary. Recommend reimbursement of $15.00.

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

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the carrier must refund the amount of the IRO fee to the requestor within 30 days of receipt of this order. The Division has determined that the requestor is entitled to reimbursement in the amount of $954.95. 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 and Order by:

	Donna Auby	1-27-06
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.

January 18, 2006

TX DEPT OF INS DIV OF WC
AUSTIN, TX 78744-1609

CLAIMANT: ___
EMPLOYEE: ___
POLICY: M5-06-0532-01
CLIENT TRACKING NUMBER: M5-06-0532-01

AMENDED DECISION 01/24/06

Medical Review Institute of America (MRIoA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Department of Insurance Division of Workers Compensation has assigned the above mentioned case to MRIoA for independent review in accordance with DWC Rule 133 which provides for medical dispute resolution by an IRO.

MRIoA 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. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the DWC approved doctor list (ADL). The reviewing provider has no known conflicts of interest existing 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 decision before referral to the IRO.

Records Received:
RECORDS RECEIVED FROM THE STATE:
2 pages Notification of IRO Assignment dated 12/22/05
3 pages Medical Dispute Resolution Request dated 11/7/05
9 pages of EOBs from DISD dated 1/24/05-3/4/05

RECORDS RECEIVED FROM THE RESPONDENT:
4 pages initial records from Bryan Weddle DC dated 1/18/05-1/21/05
TWCC-73 Work Status Report from Dr. Weddle dated 1/21/05, 1 page
4 pages of records from Dr. Weddle dated 1/24/05-1/25/05
TWCC-73 Work Status Report from Dr. Weddle dated 1/25/05, 1 page
3 page report from Charles Willis MD dated 1/25/05
27 pages of records from Dr. Weddle dated 1/26/05-3/7/05
3 TWCC-73 Work Status Report from Dr. Weddle dated 1/31/05, 2/7/05, 2/23/05
2 page right ankle MRI report dated 2/12/05
1 page right foot radiology report dated 2/22/05
2 page report from Donald Mauldin MD dated 3/1/05
TWCC-73 Work Status Report from Dr. Mauldin dated 3/1/05
4 page peer review report dated 3/2/05
14 page FCE report dated 3/4/05
TWCC-73 Work Status Report from Dr. Weddle dated 3/7/05
8 pages Report of Medical Evaluation dated 3/18/05
TWCC-73 Work Status Report from Dr. Weddle date illegible
1 page EOB dated 2/11/05

RECORDS RECEIVED FROM THE REQUESTOR
1 page letter from Southeast Health Services, Inc dated 1/13/06
2 pages titled ___ Exhibits
1 page Table of Disputed Services, 1/21/05-3/4/05
1 page treatment plan from Dr. Weddle dated 1/24/05-2/4/05
2 pages Matrix treatment sheets dated 2/18/05, 2/23/05
TWCC-73 Work Status Report from Dr. Weddle dated 3/2/05
1 page cover sheet from Initial FCE dated 3/4/05
1 page treatment plan 2/5/05-3/5/05
3 pages of rehab notes 2/7-2/21/05

Summary of Treatment/Case History:
The patient, a 58-year-old male, slipped and fell on ___ while descending a flight of stairs at work and he twisted his right ankle. He went to the chiropractor on 1/21/05 complaining of right ankle pain rated at 5/10 that was sharp and non-radiating. The examination revealed a swollen right ankle and orthopedic testing and range of motion testing was not done due to pain. The patient was diagnosed with an ankle sprain and internal derangement of the ankle joint. He was taken off work and he began a course of chiropractic and physical therapy care and he was treated on the following dates:

Jan 2005: 21, 24, 26, 27, 28, 31
Feb 2005: 1, 4, 7, 8, 11, 14,15, 18, 21, 22, 23, 28
Mar 2005: 4, 7

Charles Willis MD evaluated the patient on 1/25/05 and diagnosed him with an ankle strain of the right ankle.

The patient underwent a right ankle MRI study on 2/1/05 that revealed a 50% partial thickness tear of the peroneus longus and brevis tendons, grade I and II sprains of the anterior tibiofibular, tibiofibular, and posterior tibiofibular ligaments, mild tibialis posterior tenosynovitis, mild Achilles tendinosis in the distal five centimeters of the tendon, and a bone contusion without evidence of fracture within the lateral malleolus. Radiographs of the right ankle were unremarkable.

The patient underwent an orthopedic evaluation with Donald Mauldin MD on 3/1/05 and he had some mild swelling around the anterolateral and lateral aspect of the ankle and no evidence of subluxed tendons, Minimal tenderness was noted over the inferior tip of the fibula and ranges of motion were full and the ankle drawer test was stable. The patient was diagnosed status post right ankle sprain and with partial thickness tears of the peroneal tendons. Dr. Mauldin recommended returning the patient to work and weaning him out of his boot. The patient was returned to work at full duty without restrictions by Dr. Mauldin on 3/1/05.

A functional capacity evaluation performed on 3/4/05 revealed that the patient was able to meet his job-required physical demand level of Medium-Heavy tasks. The chiropractor returned the patient to work at full duty without restrictions as of 3/8/05.

Questions for Review:
1. Were the office visits; #99214; ultrasound #97035; electrical stimulation #97032; aquatic therapy #97113; FCE #97750-FC; and unlisted cardiovascular service #93799 from 1/21/05 to 3/4/05 medically necessary?

Explanation of Findings:
1. Were the office visits; #99214; ultrasound #97035; electrical stimulation #97032; aquatic therapy #97113; FCE #97750-FC; and unlisted cardiovascular service #93799 from 1/21/05 to 3/4/05 medically necessary?

The office visits (#99214), ultrasound (#97035), aquatic therapy (#97113), FCE (#97750-FC), and unlisted cardiovascular service (#93799) were medically necessary from 1/21/05 to 3/4/05.

The use of electrical stimulation (#97032) was medically necessary from 1/21/05 to 2/4/05 and was not medically necessary on the date of service 2/18/05. Electrical stimulation treatments on this date of service consisted of the use of Matrix Electroceutical Therapy.

Proponents of electroceutical therapy (Matrix therapy) claim that its use has resulted in significant relief of pain and elimination or drastic reductions in patients' pain medication requirements, such that patients are able to resume their daily activities. However, there is a lack of scientific evidence to substantiate these claims. Well-designed, randomized controlled clinical studies are needed to determine the usefulness of electroceutical therapy in the treatment of patients with acute or chronic pain. Aetna considers electroceutical therapy (also known as bioelectric nerve block) experimental and investigational for the treatment of acute pain or chronic pain (e.g., back pain, diabetic pain, joint pain, fibromyalgia, headache, and reflex sympathetic dystrophy) because there is a lack of scientific evidence regarding the effectiveness of this technology. (Clinical Policy Bulletin 0011: Electrical Stimulation for Pain, Aetna, February 6, 2004)

According to Medicare, any claim for therapeutic efficacy of any system of electrical stimulation must be supported by credible published data. These include claims for neuronal regeneration, headache control, post-surgical pain and relaxation of muscle spasm. The novelty of a stimulation modality, the stimulation device itself, stimulus location and treatment protocol variations do not qualify for exceptions to the requirement that there be sound evidence to support any claim. If non-standard nomenclature is used then basic and clinical science data must exist before the non-standard nomenclature qualifies for entry as a clinical terminology. For instance, “Electroceutical” is not a known clinical or MeSH terminology. Therefore, the use of this or equivalent terminology, does not automatically qualify for payment as an unclassified (NOC) (***99) procedure code. (Saty Satya-Murti MD and Patrick Price MD, “Medical Review: Electrical Stimulation as a Treatment Modality” CMS Guidelines, Medicare, Medicare, Kansas, Nebraska, NW Missouri)

Conclusion/Decision to Certify:
The office visits (#99214), ultrasound (#97035), aquatic therapy (#97113), FCE (#97750-FC), and unlisted cardiovascular service (#93799) were medically necessary from 1/21/05 to 3/4/05.

The use of electrical stimulation (#97032) was medically necessary from 1/21/05 to 2/4/05.

Conclusion/Decision to Not Certify:
The use of electrical stimulation (#97032) was not medically necessary on date of service 2/18/05.

Applicable Clinical of Scientific Criteria or Guidelines Applied in Arriving at Decision:
Saty Satya-Murti MD and Patrick Price MD, "Medical Review: Electrical Stimulation as a Treatment Modality" CMS Guidelines, Medicare, Medicare, Kansas, Nebraska, NW Missouri

References Used in Support of Decision:
Clinical Policy Bulletin 0011: Electrical Stimulation for Pain, Aetna, February 6, 2004

This review was provided by a Doctor of Chiropractic who is also a member of the American Chiropractic Academy of Neurology. This reviewer also holds a certification in Acupuncture. This reviewer has fulfilled both academic and clinical appointments and currently serves as an assistant professor at a state college, is in private practice and is a director of chiropractic services. This reviewer has previously served as a director, dean, instructor, assistant professor, and teaching assistant at a state college and was responsible for course studies consisting of pediatric and geriatric diagnosis, palpation, adjusting, physical therapy, case management, and chiropractic principles. This reviewer is responsible for multiple postgraduate seminars on various topics relating to chiropractics and has authored numerous publications. This reviewer has participated in numerous related professional activities including work groups, committees, consulting, national healthcare advisory committees, seminars, National Chiropractic Coalition, media appearances, and industrial consulting. This reviewer has been in practice since 1986.

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.

Chief Clerk of Proceedings / Appeals Clerk
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 a hearing to all other parties involved in the dispute
MRIoA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the treating provider, payor and/or URA, and the DWC.

It is the policy of Medical Review Institute of America to keep the names of its reviewing physicians confidential. Accordingly, the identity of the reviewing physician will only be released as required by state or federal regulations. If release of the review to a third party, including an insured and/or provider, is necessary, all applicable state and federal regulations must be followed.

Medical Review Institute of America retains qualified independent physician reviewers and clinical advisors who perform peer case reviews as requested by MRIoA clients. These physician reviewers and clinical advisors are independent contractors who are credentialed in accordance with their particular specialties, the standards of the American Accreditation Health Care Commission (URAC), and/or other state and federal regulatory requirements.

The written opinions provided by MRIoA represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to MRIoA for review, the published scientific medical

literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Medical Review Institute of America assumes no liability for the opinions of its contracted physicians and/or clinician advisors. The health plan, organization or other party authorizing this case review agrees to hold MRIoA harmless for any and all claims which may arise as a result of this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

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