



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, Inc P O BOX 453062 Garland, Texas 75045	MDR Tracking No.: M5-06-0535-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Ace American Insurance Company Box 15	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION: DWC-60 dispute package
POSITION SUMMARY: No position summary submitted by Requestor

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION: Response to DWC-60
POSITION SUMMARY: No position summary submitted by Respondent

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
11-09-04, 12-09-04 and 01-09-05	E0745-RR	<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 Medical Review 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 01-10-06, 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.

CPT code 99211 date of service 03-22-05 was denied by the carrier for preauthorization per Rule 134.600. Service does not require preauthorization. Per Rule 133.307(g)(3)(A-F) the requestor submitted documentation supporting the service billed. Reimbursement is recommended in the amount of **\$28.28**.

CPT code 97110 date of service 03-22-05 was denied by the carrier as global (distinct procedural service-procedure and services not normally reported together). Per the 2002 Medical Fee Guideline code 97110 is not global to code 99211 billed on the same date of service. However, recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one". Consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light of all of the Division requirements for proper documentation. The requestor did not submit documentation supporting one-on-one service, nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Reimbursement is not recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 133.307(g)(3)(A-F)

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 **\$28.28**. 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:

01-26-06

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.

MEDICAL REVIEW OF TEXAS

[IRO #5259]

10817 W. Hwy. 71
Phone: 512-288-3300

Austin, Texas 78735
FAX: 512-288-3356

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	
MDR Tracking Number:	M5-06-0535-01
Name of Patient:	
Name of URA/Payer:	Southeast Health Services
Name of Provider: (ER, Hospital, or Other Facility)	Southeast Health Services
Name of Physician: (Treating or Requesting)	Bryan Weddle, DC

January 5, 2006

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on the Division of Workers' Compensation Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Division of Workers' Compensation

CLINICAL HISTORY

Documentation submitted for review:

- * Chiropractic Notes and Reports – Bryan Weddle, DC
- * Letter of Medical Necessity – Bryan Weddle, DC
- * Request for Reconsideration – Bryan Weddle, DC
- * EOBs – AccuMed
- * Review of Documents – Intracorp Medical Services
- * Review of Medications Prescribed - Pharmacy Review Services
- Orthopedic Reports, Operative Reports – Richard Levy, MD

- * Pain Management Reports – CM Schade, MD, PhD
- * Pain Management Reports – Deborah Westergaard, MD
- * Billing Invoice and Table of Disputed Services – Southeast Health Services Inc.

Available information suggests that this patient reports experiencing an occupational injury occurring on ___ when a section of sheet metal flipped over from his concrete truck and struck him. He was diagnosed with both right and left rotator cuff tear and was seen for a period of several months for conservative care with a chiropractor, Bryan Weddle, DC. The patient ultimately underwent shoulder surgery with Richard Levy, MD on 03/06/05. The patient also had pain management consultations with CM Schade, MD and Deborah Westergaard, MD who provided medications, nerve blocks and myoneural injections. On 11/09/04 the chiropractor appears to provide the patient with multiple passive modalities including electric muscle stimulation and is prescribed EMS neuromuscular stimulator for home use. This item appears to be billed to the carrier again on 12/09/04 and 01/09/05 as well with no specific explanation for this duplication. Orthopedic and pain management consultations make no suggestions or recommendations for utilization of EMS, neuromuscular stimulator or TENS unit device for these conditions. Pain management consultation report of 05/19/05 by Deborah Westergaard, MD appears to note that EMS/TENS type unit appears to make the patient's pain worse.

REQUESTED SERVICE(S)

Determine medical necessity for neuromuscular stimulator (E0745-RR) on 11/09/04, 12/09/04, and 01/09/05.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

Medical necessity for EMS Purchase (E0745-RR) on the above dates is not supported by available documentation submitted. Available medical, pain management and rehabilitation literature suggests that passive muscle and nerve stimulators of this nature (including EMS/TENS) have demonstrated little evidence of clinical effectiveness and no evidence for more than transient pain modulation. Clinical notations from Dr. Westergaard suggesting that this device actually makes the patient's pain "worse" is further rationale against medical necessity.

1. Philadelphia Panel Evidence-Based Clinical Practice Guidelines on Selected Rehabilitation Physical Therapy, Volume 81, Number 10, October 2001.
2. Hurwitz EL, et al. The effectiveness of physical modalities among patients with low back pain randomized to chiropractic care: Findings from the UCLA Low Back Pain Study. J Manipulative Physiol Ther 2002; 25(1):10-20.
3. Bigos S., et. al., AHCPR, Clinical Practice Guideline, Publication No. 95-0643, Public Health Service, December 1994.
4. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Mercy Center Consensus Conference, Aspen Publishers, 1993.
5. Swenson RS. "Therapeutic modalities in the management of pain", Phys. Med. Rehabilitation Clin. N. Am. 2003 Aug; 14(3):605-27.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials.

No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned individual. These opinions rendered do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.

Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that I have no known conflicts of interest between the 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.

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
Division of Workers' Compensation
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell