



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 Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address: San Antonio Spine & Rehabilitation P O BOX 240970 San Antonio, Texas 78224	MDR Tracking No.: M5-06-1115-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Amerisure Insurance Company Box 47	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60 dispute
POSITION SUMMARY: Per the table of disputed services "medically necessary treatment".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60
POSITION SUMMARY: None 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)
02-24-05 to 03-30-05	99205-25, 99212-59 and 97113-59	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
02-24-05	99080-73	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$15.00
02-24-05 to 03-30-05	G0283 (1 unit @ \$13.61 X 12 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$163.32
02-24-05 to 03-30-05	97012 (1 unit @ \$17.76 X 14 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$248.64
02-24-05 to 03-30-05	97140-59 (1 unit @ \$31.73 X 16 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$507.68
02-24-05 to 03-30-05	97035 (1 unit @ \$14.63 X 14 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$204.82
03-28-05 & 3-30-05	97110 (3 units @ \$100.68 X 2 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$201.36
TOTAL			\$1,340.82

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 134.202

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 \$1,340.82. In addition, 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:

Authorized Signature

4/14/06

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

REVISED 4/12/06

TDI-WC Case Number:	
MDR Tracking Number:	M5-06-1115-01
Name of Patient:	
Name of URA/Payer:	San Antonio Spine & Rehabilitation
Name of Provider: (ER, Hospital, or Other Facility)	San Antonio Spine & Rehabilitation
Name of Physician: (Treating or Requesting)	Joseph Flood, DC

April 7, 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

REVISED 4/12/06

CLINICAL HISTORY

Documents Reviewed Included the Following:

1. Notification of IRO Assignment, Table of Disputed Services, Carrier EOBs
2. MRI cervical spine with report, **dated 7/23/04**
3. Orthopedic surgeon's report of patient encounter, **dated 8/5/04**
4. Initial ER and hospital records immediately post-injury, dated 9/10/04
5. Medical report, dated 10/19/04, 11/02/04, 12/7/04
6. Physical therapy notes, October, November and December 2004, and January 2005
7. Designated doctor examination, report and TWCC-69, dated 1/11/05
8. Medical pain management initial evaluation and report, dated 1/12/05
9. Medical record review, dated 1/12/05
10. Medical pain management follow-up note, dated 2/2/05
11. Functional capacity evaluation, dated 2/4/05
12. Case manager notes
13. Independent medical evaluation and report, dated 2/13/05
14. Initial evaluation and report, dated 2/24/05
15. Carrier review, dated 4/5/05
16. Treating doctor's Request for Reconsideration, dated 4/28/05
17. Medical doctor's initial evaluation, 4/11/05
18. Physical performance evaluation, dated 3/30/05
19. Treating doctor of chiropractic's daily treatment notes, multiple dates
20. Work hardening assessment, dated 3/30/05
21. Work hardening weekly notes, multiple dates (April and May 2005)
22. MRI report of the cervical spine, dated 1/27/05
23. EMG/NCV with report, dated 4/14/05
24. MRI report of the right shoulder, dated 5/14/05
25. Designated doctor examination, report and TWCC-69, dated 7/27/05
26. Designated doctor letter of clarification, dated 8/2/05
27. Treating doctor referred impairment rating, dated 5/10/05
28. Various TWCC-73s

Patient is a 48-year-old male carpenter who, on ____, was injured when a co-worker dropped a ladder onto him, striking the right side of his neck and right shoulder. He was taken to the hospital, x-rayed, and prescribed medication, some passive therapy, and home exercises. He then received physical therapy, medication, and was performing home exercises, but later reported that he believed the exercises were making his condition worse. So, he presented himself to a doctor of chiropractic for continuation of his care.

REQUESTED SERVICE(S)

Office visit, level V, new patient (99205-25), office visit, level II, established patient (99212-59), DWC reports (99080-73), electrical stimulation, unattended (G0283), therapeutic exercises (97110), mechanical traction (97012), manual therapy techniques (97140-59), ultrasound (97035), and aquatic therapy (97113-59) for dates of service 2/24/05 through 3/30/05.

DECISION

The unattended electrical stimulation (G0283), the ultrasound (97035), the manual therapy techniques (97140-59), the therapeutic exercises (97110), the DWC reports (99080-73) and the mechanical traction (97012) are all approved.

All remaining services and procedures are denied.

RATIONALE/BASIS FOR DECISION

In this case, the medical records adequately demonstrated that a compensable injury occurred to the claimant's neck and right shoulder. Furthermore, the records showed that the patient responded initially well to a physical therapy regimen, and was even deemed MMI on this program in mid January, following a ____ injury. Therefore, it was reasonable to assume that when the flare-up occurred, a similar regimen would again fulfill the statutory requirements¹ for medical necessity by providing relief, promotion of recovery and enhancement of the employee's ability to return to employment. And indeed, the medical records provided revealed that this was the case.

¹ Texas Labor Code 408.021

However, in terms of the office visit, new patient (99205), nothing in either the diagnosis or the medical records submitted suggested the need for such a high level Evaluation and Management (E/M), according to CPT 2. Indeed, the medical decision-making alone was fairly straight forward, so the medical necessity of performing such a high level service was unsupported. Likewise, the level II established patient office visits (99212-59) were also unsupported as medically necessary, as nothing in the records supported the performance of this level service on each and every patient encounter, particularly not during an already-established treatment plan.

It is equally important to mention that several studies^{3 4 5 6 7 8} have proven the effectiveness of spinal manipulation for patients with cervical spine symptoms and conditions. Nothing in the records submitted suggest that this procedure was performed. For that reason, it is difficult to understand why a doctor of chiropractic would attempt a host of other therapies while withholding a proper regimen⁹ of spinal manipulation.

In closing, it is noteworthy to point out that – according to the records submitted for review – this claimant was involved in a side-impact motor vehicle accident on ____, just a few months before the on-the-job injury in dispute here even occurred. According to the only medical report available from that incident, the patient sustained an injury to his neck, and was experiencing neck pain, as well as left hand pain, tingling and numbness. A cervical MRI was then performed on 7/23/04 and (although the actual films are not available for comparison) the report reads nearly identically to the post-industrial MRI performed some months later. Despite this documented event, on each and every medical report referable to the workers' compensation injury of ____, the "past medical history" sections state "non-contributory" or "unremarkable for any illness," although these other records suggest something altogether different.

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.

2 CPT 2004: *Physician's Current Procedural Terminology, Fourth Edition, Revised*. (American Medical Association, Chicago, IL 1999),

3 Hurwitz EL, Morgenstern H, Harber P, Kominski GF, Yu F, Adams AH. A randomized trial of chiropractic manipulation and mobilization for patients with neck pain: clinical outcomes from the UCLA neck-pain study. *Am J Public Health*. 2002 Oct;92(10):1634-41.

4 Hoving JL, Koes BW, de Vet HC, van der Windt DA, Assendelft WJ, van Mameren H, Deville WL, Pool JJ, Scholten RJ, Bouter LM. Manual therapy, physical therapy, or continued care by a general practitioner for patients with neck pain. A randomized, controlled trial. *Ann Intern Med*. 2002 May 21;136(10):713-22.

5 Gross AR, Hoving JL, Haines TA, Goldsmith CH, Kay T, Aker P, Bronfort G, Cervical overview group. Manipulation and Mobilisation for Mechanical Neck Disorders. *Cochrane Database Syst Rev*. 2004;1:CD004249.

6 Koes, B, Bouter, L, et al. Randomised clinical trial of manipulative therapy and physiotherapy for persistent back and neck complaints: results of one year follow up. *BMJ* 1992;304:601-5.

7 Koes BW, Bouter LM van Mameren H, et al. A randomized clinical trial of manual therapy and physiotherapy for persistent neck and back complaints: sub-group analysis and relationship between outcome measures. *J Manipulative Physio Ther* 1993;16:211-9.

8 Cassidy JD, Lopes AA, Yong-Hing K. The immediate effect of manipulation versus mobilization on pain and range of motion in the cervical spine: A randomized controlled trial. *J Manipulative Physio Ther* 1992;15:570-5.

9 Haas M, Group E, Kraemer DF. Dose-response for chiropractic care of chronic low back pain. *Spine J*. 2004 Sep-Oct;4(5):574-83. "There was a positive, clinically important effect of the number of chiropractic treatments for chronic low back pain on pain intensity and disability at 4 weeks. Relief was substantial for patients receiving care 3 to 4 times per week for 3 weeks."

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