



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: Patrick R. E. Davis, D.C. 115 W. Wheatland Road Ste 101 Duncanville, Texas 75116	MDR Tracking No.: M5-06-1161-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Risk Management Fund Rep 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 package.
POSITION SUMMARY: Per the table of disputed services "documentation supports medical necessity".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No response was received from the carrier

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
03-01-05 to 04-08-05	97110-59 (3 units found to be necessary by IRO) (See note below regarding reimbursement of 1 unit @ \$36.14 X 17 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$614.38
03-01-05 to 04-08-05	97110-59 (3 units)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
04-12-05	E0745-RR	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
04-12-05 to 05-06-05	97530-59	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
	Note: The Requestor billed for 6 units of 97110-59 and has been paid for 2 units for the DOS in dispute. Additional reimbursement is recommended for 1 unit for each DOS in dispute.		

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 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 03-28-06, 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.

Date of service 02-25-05 was per Rule 133.308(e)(1) not timely filed and is not eligible for review.

HCPCS code E1399-NU dates of service 03-14-05 and 04-20-05 was denied by the carrier as "the procedure code is inconsistent with the modifier used or a required modifier is missing". Per the 2005 DMEPOS Fee Schedule code E1399 is not a valid HCPCS code. No reimbursement recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.202 and 2005 DMEPOS Fee Schedule

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 \$614.38. 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:

05-25-06

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.

**IRO Medical Dispute Resolution M5 Retrospective Medical Necessity
IRO Decision Notification Letter**

Date:

05/17/2006

CORRECTED COPY

	05/19/2006
Injured Employee:	
MDR #:	M5-06-1161-01
DWC #:	
MCMC Certification #:	TDI IRO-5294

REQUESTED SERVICES:

Please review the item(s) in dispute: Therapeutic exercises (97110-59), therapeutic activities (97530-59) and neuromuscular stimulator (E0745-RR).

Dates of Service (DOS): 03/01/2005-05/06/2005

DECISION: Partial

IRO MCMCIIc (MCMC) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO) to render a recommendation regarding the medical necessity of the above disputed service.

Please be advised that a MCMC Physician Advisor has determined that your request for an M5 Retrospective Medical Dispute Resolution on 05/17/2006, concerning the medical necessity of the above referenced requested service, hereby finds the following:

The documentation establishes the medical necessity for the application of three units of 97110 from 03/01/2005 through 05/06/2005. There is no established medical necessity for the utilization of more than three units of 97110 per date of visit and further there is no established medical necessity for the application of 97530, therapeutic activities, as well as E0745-RR, neuromuscular stimulator.

CLINICAL HISTORY:

Records indicate that the above captioned individual, a 44 year old male, presented to the office of the attending physician (AP) on _____ complaining of pain in the low back and lower extremities following an occupational incident that allegedly occurred on or about _____. The history reveals that the injured individual was working as a _____ setting and, during the course of his normal employment, tried to free a person who was pinned in a car following a traffic accident. The injured individual exhibited decreased ranges of motion in the lumbar spine as well as positive orthopedic testing and neurologic deficits in the lower extremities. A course of chiropractic management ensued to include manipulation, myofascial release, passive care as well as active rehabilitation. A neuromuscular stimulator was also issued for home use. There are no indications that any radiographic techniques were employed including plain film x-ray and/or MRI. An electrodiagnostic examination was performed on 04/11/2005, which suggested the presence of an L5 radiculopathy on the left.

REFERENCES:

- ACEOM Guidelines.
- Health Care Guidelines by Milliman and Robertson Volume 7.
- North American Spine Society Guidelines.
- Texas Medical Fee Guidelines, and Procedural Utilization Guidelines.

RATIONALE:

In regards to the utilization of the neuromuscular stimulator, the documentation establishes no rationale or medical necessity for this entity. Specifically, there is no indication within the clinical notations that a clinical trial of the unit was attempted or documented. Furthermore, there are no indications within the documentation of any quantifiable response to the specific treatment of the neuromuscular stimulator. The file makes some empirical references to the utilization of the unit, however, there are no pre and post pain values to indicate the response to care. Lastly, there is no research evidence that the utilization of this modality for long term is efficacious. In fact, there is evidence that the long-term utilization of such a device fosters chronicity and increases the dependence for provider driven care. The documentation establishes no rationale or medical necessity for the initiation of this specific modality as prescribed.

In regards to therapeutic exercises, 97110, the documentation establishes that the injured individual was an appropriate candidate for the initiation of this modality. The injured individual had documented functional deficits including ranges of motion and orthopedic testing. The documentation also establishes that during the treatment period in question the injured individual progressed in terms of improved ranges of motion and orthopedic testing. However, the documentation does not establish the need for 4-6 units of this modality. There are no unusual circumstances or clinically correlated complicating factors that would establish the need for that particular level of care, up to six units. The

injured individual tested positive for the presence of a lumbar radiculopathy, however there is no clinical correlation with radiographic findings to establish that the radiculopathy represented a significant complicating factor to warrant the application of this modality for an unusual length for each visit, i.e. up to six units. This is especially applicable given the fact that this case does not involve multiple areas of involvement, but rather involves treatment to the low back principally.

In regards to the therapeutic activities, 97035, the documentation does not establish that there was one on one physician contact. The utilization of this code requires one on one physician contact during the actual treatment modality. Further, the documentation does not establish the need for this level of care over the utilization of a lesser code or lower form of care such as 97110, which does not require one on one physician contact.

To summarize, the medical necessity for the application of 97110 for up to three units is established for the dates of service in dispute. However the medical necessity for the application of all other treatment captioned above is not established.

RECORDS REVIEWED:

- Notification of IRO Assignment dated 03/28/06
- MR-117 dated 03/28/06
- MR-116 dated 03/28/06
- DWC-60
- MCMC: IRO Medical Dispute Resolution Retrospective Medical Necessity dated 04/20/06
- MCMC: IRO Acknowledgment and Invoice Notification Letter dated 03/29/06
- Injury Solutions-Duncanville: Letters dated 05/06/05, 04/09/05, 03/11/05, 02/09/05 from Dr. Patrick R.E. Davis
- G. Kris Wilson, B.S., D.C.: Office notes dated 04/12/05 through 05/06/05
- Injury Solutions at Duncanville: Kinetic Procedures: Lumbar Spine Rehabilitation notes dated 04/12/05 through 05/06/05
- R. Frank Morrison, M.D.: EMG/NCS Report dated 04/11/05
- Explanation of Medical Benefits with handwritten dates of 03/01/05, 03/02/05, 03/07/05, 03/09/05, 03/11/05, 03/14/05, 03/16/05, 03/18/05, 03/21/05, 03/23/05, 03/25/05, 03/28/05, 03/30/05, 04/01/05, 04/04/05, 04/06/05, 04/08/05, 04/12/05, 04/15/05, 04/20/05, 04/22/05, 04/26/05, 04/28/05, 04/29/05, 05/02/05, 05/04/05, 05/06/05
- Patrick R.E. Davis, B.S., D.C.: Office notes dated 03/01/05 through 04/09/05
- Injury Solutions of Duncanville: Therapeutic Procedures: Lumbar Spine Rehabilitation notes dated 02/25/05 through 04/09/05

The reviewing provider is a Licensed/Boarded Chiropractor and certifies that no known conflict of interest exists between the reviewing Chiropractor 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 prior to referral to the IRO. The reviewing physician is on DWC's Approved Doctor List.

This decision by MCMC is deemed to be a Division decision and order (133.308(p) (5)).

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.

In accordance with Division rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent via facsimile to the office of DWC on this

___17th day of ___MAY_____ 2006.

Signature of IRO Employee: _____

Printed Name of IRO Employee: _____

**MCMC llc ▪ 88 Black Falcon Avenue, Suite 353 ▪ Boston, MA 02210 ▪ 800-227-1464 ▪ 617-375-7777 (fax)
mcmman@mcmman.com ▪ www.mcmman.com**