



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: SCD Back and Joint Clinic, Ltd 200 E. 24 th Street, Suite B Bryan, Texas 77803	MDR Tracking No.: M5-06-1488-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Insurance Company Rep Box # 54	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: "The carrier denied payment for certain medical services provided to the above captioned patient. It is our position that these services were reasonable, necessary, and related to the compensable injury. Appeals and follow up with the carrier have failed to resolve the dispute".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60

POSITION SUMMARY: "Therefore, Texas Mutual requests that the request for dispute resolution filed by SCD BACK & JOINT CLINIC LTD, be conducted under the provisions of the APA set out above".

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
04-05-05 to 11-29-05	99211, 99212, 99213, 97530, 97112, 97124, 97012, 97750, G0283, 97026, 98940, 98941, 98943, L1499, 97039, 97024, 99361 and L0120	<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 05-09-06, 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 97012 date of service 04-08-05 denied with denial code "97" (payment is included in the allowance for another service/procedure). Per the 2002 Medical Fee Guideline code 97012 is not global to any other service billed on the date of service in dispute. Reimbursement is recommended in the amount of **\$17.20** billed by the Requestor.

CPT code 97750 date of service 04-14-05 denied with denial code "97" (payment is included in the allowance for another service/procedure). Per the 2002 Medical Fee Guideline code 97750 is not global to any other service billed on the date of service in dispute. Reimbursement is recommended in the amount of **\$100.20** billed by the Requestor.

CPT code G0283 date of service 05-02-05 denied with denial code "18" (duplicate claim/service). Since neither party submitted an original EOB the review will be per Rule 134.202. Reimbursement is recommended in the amount of **\$13.61**.

CPT code 99080 date of service 06-14-05 denied with denial code "97" (payment is included in the allowance for another service/procedure). Per the 2002 Medical Fee Guideline this is a bundled code. No reimbursement recommended.

CPT code 99080-73 date of service 06-22-05 denied with denial code "U" (unnecessary medical treatment). Per Rule 129.5 this is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. Recommend reimbursement in the amount of **\$15.00**.

CPT code 99361 date of service 07-05-05 denied with denial code "97" (payment is included in the allowance for another service/procedure). Per the 2002 Medical Fee Guideline this is not global to the other service billed on the date of service. Reimbursement is recommended in the amount of **\$53.00**.

CPT code 99371 dates of service 07-18-05, 07-25-05 and 08-10-05 were denied with denial code "97" (payment is included in the allowance for another service/procedure). Review of the CMS 1500's submitted revealed that no other service was billed on the dates of service in dispute. Reimbursement recommended in the amount of **\$33.00 (\$11.00 X 3 DOS)**.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.202 and 129.5

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 \$232.01. 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:

06-13-06

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.

June 7, 2006

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

CLAIMANT: ____

EMPLOYEE: ____

POLICY: M5-06-1488-01

CLIENT TRACKING NUMBER: M5-06-1488-01

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 from state:

Texas Department of Insurance, Division of Workers' Compensation (DWC) Notification of IRO Assignment – 20 pages

Records from requestor:

Letter to MRIoA from John Wyatt, DC 06/01/06 – 2 pages

Information Request from MRIoA 05/31/06 – 1 page

Letter to Back and Joint Clinic from DWC 05/09/06 – 1 page

Initial Medical Narrative Report, Dr. Wyatt 03/17/05 – 6 pages

Work Status Report 03/17/05 – 1 page

Lumbar Home Exercise Program instructions – 1 page

Cervical Home Exercise Program instructions – 1 page

Home Ice Therapy instructions – 1 page

Subsequent Medical Narrative Report 04/12/05 – 14 pages

Work Status Report 04/14/05 – 1 page

Subsequent Medical Narrative Report 06/09/05 – 12 pages

Work Status Report 06/10/05 – 1 page

Subsequent Medical Narrative Report 06/30/05 – 5 pages

Work Status Report 06/30/05 – 1 page

Work Status Report 03/23/05 – 1 page

Work Status Report 03/24/05 – 1 page

Work Status Report 03/28/05 – 1 page

Work Status Report 04/04/05 – 1 page

Work Status Report 05/17/05 – 1 page

Work Status Report 05/19/05 – 1 page

Work Status Report 06/17/05 – 1 page

Work Status Report 06/20/05 – 1 page

Work Status Report 06/21/05 – 1 page

Work Status Report 06/22/05 – 1 page

Work Status Report 06/27/05 – 1 page

Work Status Report 07/12/05 – 1 page

Work Status Report 07/19/05 – 1 page

Work Status Report 07/26/05 – 1 page

Work Status Report 08/17/05 – 1 page

Work Status Report 08/26/05 – 1 page

Work Status Report 11/04/05 – 1 page

Muscle Testing Report, DeLorme Testing– 3 pages
Initial Treatment Plan 03/21/05 – 3 pages
1st Major Revision Treatment Plan 04/01/05 – 4 pages
2nd Major Revision Treatment Plan 04/11/05 – 4 pages
2nd Major Revision Treatment Plan 04/18/05 – 4 pages
3rd Major Revision Treatment Plan 04/25/05 – 4 pages
4th Major Revision Treatment Plan 05/03/05 – 4 pages
5th Major Revision Treatment Plan 05/10/05 – 4 pages
6th Major Revision Treatment Plan 05/19/05 – 4 pages
7th Major Revision Treatment Plan 05/31/05 – 4 pages
8th Major Revision Treatment Plan 06/13/05 – 4 pages
9th Major Revision Treatment Plan 06/27/05 – 4 pages
#97530 Progressive Resistance Exercise Chart 04/18-06/22/05 – 22 pages
Patient office visit reports 03/17-02/09/06 – 93 pages
Biofreeze 4oz Tube 03/16/05 – 1 page
Therapeutic Ice Packs 03/17/05 – 1 page
Sitback Rest 04/22/05 – 1 page
LSI Therasleep Fiber Pillow Standard 24x16 05/06/05 – 1 page
Biofreeze 4oz Tube 05/19/05 – 1 page
Diamondback Heel lift-Orthotics 05/24/05 x2 – 1 page
Sitback Rest 11/29/05 – 1 page
Re: Pain Medication Evaluation 03/21/05 – 1 page
Re: Pain Medication Evaluation/Individual Therapy 03/21/05 – 1 page
Assessment/Physical Examination, Issan Shanti, MD, PhD 04/19/05 – 4 pages
Re: MRI 03/31/05 – 1 page
Lumbar MRI report 04/07/05 – 1 page
Re: MRI 04/14/05 – 1 page
Cervical MRI report 04/21/05 – 1 page
Right Shoulder MRI report 04/21/05 – 1 page
Re: Individual Therapy Evaluation 05/11/05 – 1 page
Procedure report, Dr. Shanti 06/16/05 – 3 pages
Re: Neurological Evaluation 06/01/05 – 1 page
Worker's Compensation Narrative Report, Randall Light, MD 07/14/05 – 3 pages
Electromyography Report, Dr. Light 07/14/05 – 1 page
Re: Orthopedic Consultation 07/26/05 – 1 page
Orthopedic consultation, Ernest T. Roman, MD 08/02/05 – 3 pages
Re: Medical Branch Block/Radiofrequency Evaluation and Treatment of Lumbar Spine 08/17/05 – 1 page
Letter to patient from Amy L. Holcomb/Texas Mutual Insurance Company 09/08/05 – 2 pages
Procedure report, Dr. Shanti 12/15/05 – 3 pages
Re: Psychological Evaluation and Treatment Recommendations 09/28/05 – 1 page
Psychological evaluation, Lois M. Hansen, MA, LPC-S 10/04/05 – 6 pages
Letter to Dr. Wyatt from Amy Holcomb 10/07/05 – 2 pages
Session notes 01/10/06 – 1 page
Progress notes 02/06-02/08/06 – 3 pages
IRO Submission Appendix A – 14 pages
IRO Submission Appendix B – 9 pages
IRO Submission Appendix C – 4 pages
IRO Submission Appendix D – 3 pages
IRO Submission Appendix E – 3 pages
IRO Submission Appendix F – 2 pages

Summary of Treatment/Case History:

Claimant underwent diagnostic imaging and physical medicine treatments after sustaining injury to his shoulder, cervical spine, thoracic spine and lumbar spine in a MVA on ____.

Questions for Review:

Items in dispute: #99211, #99212, #99213-office visits, #97530-therapy activities, #97112-neuromuscular re-ed, #97124-massage, #97012-mech tract, #97750-Delorme muscle test, #97750-Dynatron human perform test, #G0283-elec stim therapy, #97026-low level light therapy, #98940, #98941, #98943 chirop manip, #L1499-cervical pillow, #97039-cold laser, #97024-diathermy, #99361-med conf, #L0120 sitback rest.

1. Were the items in dispute from 04/05/05 through 11/29/05 medically necessary to treat this patient's injury?

Explanation of Findings:

1. Were the items in dispute from 04/05/05 through 11/29/05 medically necessary to treat this patient's injury?

No. The *Guidelines for Chiropractic Quality Assurance and Practice Parameters* (1) Chapter 8 under “Failure to Meet Treatment/Care Objectives” states, “After a maximum of two trial therapy series of manual procedures lasting up to two weeks each (four weeks total) without significant documented improvement, manual procedures may no longer be appropriate and alternative care should be considered.” The ACOEM Guidelines (2) state that if manipulation does not bring improvement in three to four weeks, it should be discontinued. While physical medicine is an accepted part of a rehabilitation program following an injury, for medical necessity to be established, there must be an expectation of recovery or improvement within a reasonable and generally predictable time period. In addition, the frequency, type and duration of services must be reasonable and consistent with the standards of the health care community. Expectation of improvement in a patient’s condition should be established based on success of treatment. Continued treatment is expected to improve the patient’s condition and initiate restoration of function. If treatment does not produce the expected positive results, it is not reasonable to continue that course of treatment.

In this case, there is no documentation of subjective, objective or functional improvement in this patient’s condition. In fact, not a single shoulder or spinal range of motion was quantitative measured or recorded at any time. There was also no support for continuing past unsuccessful treatment as documented by the claimant’s pain rating of 5/10 near the start of treatment on 03/21/05; 5/10 on 04/05/05 at the initiation of the disputed treatment; either 5/10 or 6/10 on almost all dates of service during the 8 months of treatment; and 6/10 on 11/29/05 at the termination of the disputed treatment.

Therefore, the disputed services failed to fulfill statutory requirements (3) for medical necessity since the patient obtained no relief, promotion of recovery was not accomplished and there was no enhancement of the employee’s ability to return to or retain employment. To some degree, the claimant’s lack of positive response was foreseeable since the ACOEM Guidelines state that passive modalities such as massage and diathermy have no proven efficacy in treating acute low back symptoms and that there is no high-grade scientific evidence to support the effectiveness of passive modalities such as traction, heat/cold applications, massage and diathermy for cervical spine conditions.

Conclusion/Decision to Not Certify:

The items in dispute from 04/05/05 through 11/29/05 are not medically necessary to treat this patient’s injury.

References Used in Support of Decision:

1. Haldeman, S; Chapman-Smith, D; Petersen, D *Guidelines for Chiropractic Quality Assurance and Practice Parameters*, Aspen Publishers, Inc.
2. *ACOEM Occupational Medicine Practice Guidelines: Evaluation and Management of Common Health Problems and Functional Recovery in Workers, 2nd Edition.*
3. Texas Labor Code 408.021

This review was provided by a chiropractor licensed in Texas, certified by the National Board of Chiropractic Examiners, and who is a member of the American Chiropractic Association and has several years of licensing board experience. This reviewer has written numerous publications and given several presentations with their field of specialty. This reviewer has been in continuous active practice for over twenty-five years.

MRIOA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to 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.