



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:	MDR Tracking No.: M5-06-1647-01
Health and Medical Practice Associates 324 N. 23 rd St. Ste. 201 Beaumont, TX 77707	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Commerce and Industry Insurance, Box 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary (Table of Disputed Services) states, "Medical Necessity."

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. CMS-1500's
3. EOB's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary states, "As of December 1, 2005, all physical therapy is subject to preauthorization prior to rendition of service... On December 15, 2005, carrier's utilization review agent issued preauthorization for only 6 sessions of physical therapy."

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. CMS-1500's
3. EOB's

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)
9-21-05 – 12-14-05	99213 (\$62.19 x 3 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$186.57
10-17-05 – 10-28-05	97530	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
10-17-05 – 10-28-05	97124	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
10-17-05 – 10-28-05	97032	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
Grand Total			\$186.57

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. The amount due the Requestor for the items denied for medical necessity is \$186.57.

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.

CPT codes 97032, 97124, and 97530 from 12-16-05 through 12-30-05 were denied by the carrier as "50-these are non-covered services because this is not deemed a 'medial necessity' by the payer," and "172-payment is adjusted when performed/billed by a provider of this specialty." The Requestor provided a copy of a preauthorization letter dated December 15, 2005 which authorizes six sessions of Physical Therapy. Rule 133.301 (a) states "Respondent shall not retrospectively review the medical necessity of a medical bill for treatments (s) and/or service (s) for which the health care provider has obtained preauthorization under Chapter 134 of this title." Recommend reimbursement per 134.202 as follows:

97032 – (12 units x \$19.09) = \$229.08

97124 – (6 units x \$26.73) = \$160.38

97530 – (12 units x \$35.34) = \$424.08

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.301, 133.308, 134.1, and 134.202(c)(1)
Texas Labor Code 413.011 and 413.031

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 Division has determined that the Requestor is not entitled to a refund of the paid IRO fee. The Division has determined that the Requestor is entitled to reimbursement for the services involved in this dispute in the amount of \$1,000.11. The Division hereby **ORDERS** the Respondent 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:

Medical Dispute Officer

10-02-06

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.

July 5, 2006

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

CLAIMANT: ____

EMPLOYEE: ____

POLICY: M5-06-1647-01

CLIENT TRACKING NUMBER: M5-06-1647-01-5278

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:

Notification of IRO assignment 6/7/06, 8 pages

Explanation of review forms; 11/22/05-1/18/06, 9 pages

RECORDS RECEIVED FROM THE REQUESTOR:

Letter from health & Medical Practice Assoc to MRIOA dated 6/30/06, 7 pages

Lumbar spine MRI report 2/24/05, 1 page

PM&R medical necessity and coverage -local policy Medicare part B newsletter 3/14/03, 9 pages

General PM&R guidelines, 6 pages

Daily note reports; 9/21/05-10/28/05, 6 pages

Functional capacity evaluation 4/8/05, 19 pages

Consult 9/8/05 - A. Dumitru MD, 2 pages

UR determination 12/15/05, 1 page

Reevaluation 11/2/05-A. Dumitru MD, 1 page

Billing retrospective review 5/17/05, 3 pages

Information on epidural steroid injections, web page R. Stahler MD, undated, 4 pages

EOB's for ESI therapy, 6 pages

Texas work comp language, 4 pages

Request for myelogram 4/7/06, 10 pages

Medical progress notes; 9/21/05, 10/19/05, 11/16/05, 12/14/05, 13 pages

Daily treatment notes; 10/19/05-10/28/05, 12/16/05-12/30/05, 22 pages

Medicare fee guidelines, 1 page

Billing records 9/21/05-12/30/05, 15 pages

EOB letters, 22 pages

References, 1 page

RECORDS RECEIVED FROM THE RESPONDENT:

Letter to MRIOA from Flahive, Ogden & Latson dated 6/14/06, pages

Attorney letter 5/30/06, 2 pages

Summary of Treatment/Case History:

This is a patient with a work related injury on ____ with onset of pulling sensation in the right shoulder and back. The patient has ongoing pain in these areas that is radiating down the right leg. An MRI study on 2/24/05 demonstrated 2 mm diffuse disc bulge at L4-5 and L5-S1 without evidence of neural involvement or stenosis. No abnormalities were apparently noted on the thoracic spine MRI. The patient has been treated with rest, medications, and therapy without significant improvement. The notes indicate that the low back with leg discomfort were the

major areas of discomfort when seen in consult on 9/8/05. The patient had ESI (10/13/05 and 12/6/05) and facet blocks done with improvement in pain complaints.

The patient has apparently been in treatment since the injury. The dates of 9/21/05-12/14/05 are in dispute. Services during these dates include therapy modalities (#97530, #97032 and #97124) and E/M visits (#99213).

Questions for Review:

DOS: 9/21/05 through 12/14/05:

1. Please review the following for medical necessity. Office visits (#99213), therapeutic activities (#97530), electrical stimulation (#97032) and massage therapy (#97124).

Explanation of Findings:

The clinical documentation is essentially limited to the dates in dispute. However, the retrospective review of 5/17/05 indicates that the patient also had a previous work related injury on ___ and the patient had ongoing neck and back problems as a result of that injury. A cervical spine MRI was done on 12/13/04 just prior to the present injury indicating that those injuries had not resolved. Also, the physician progress notes indicate ongoing care since the time of the present injury. This information indicates a patient with chronic pain not improving with the conservative therapy being provided. It should also be noted that the physician progress notes mentions a number of sensory studies which provides at least part of the rationale upon which treatment is based.

1. Please review the following for medical necessity. Office visits (#99213), therapeutic activities (#97530), electrical stimulation (#97032) and massage therapy (#97124).

In regards to the therapy provided, the prior denial should be upheld. There is no literature support for ongoing therapy in patients with chronic pain especially when no objective sustained improvement is noted after prolonged treatment. There is no support for electrical stimulation (#97032) as a therapy modality in such patients as there is no literature support for its use in this manner. There is no literature data that it will help improve function in such patients. If electrical stimulation provides pain relief then a TENS unit for ongoing home use may be appropriate. There is no literature support for manual therapy (#97530) in chronic pain over a prolonged treating period. There is no data that this provides anything other than short term symptomatic relief and this then becomes a maintenance program. There is also inadequate documentation support for the therapy (#97124). The notes are generic in nature and not specific to the patient, indicating specifically what was done and what was accomplished. The notes do not indicate any sustained objective improvement. All the treatment notes are essentially the same.

In regards to the physician reevaluations (#99213), the denial should be overturned. The patient does remain symptomatic and does require ongoing physician management. The physician is prescribing narcotics. He is deciding on referrals and other treatment options. Monthly reevaluations are reasonable and what is generally done clinically. The exams on these reevaluations are rather limited but would be consistent with CPT #99213.

Conclusion/Decision to Certify:

Medical necessity has been established for the physician reevaluations, CPT #99213, on a monthly basis.

Conclusion/Decision to Not Certify:

Medical necessity has not been established for any of the therapy provided (CPT #97530, #97124 and #97032).

Applicable Clinical of Scientific Criteria or Guidelines Applied in Arriving at Decision:

Clinical review

References Used in Support of Decision:

Myofascial pain: Focused review. Arch PM&T March 2002, 83(3), suppl 1, s40-s47

Electrical stimulation. CIM Manual section 35-46

Philadelphia Panel. Philadelphia Panel evidence-based clinical practice guidelines on selected rehabilitation interventions: overview and methodology. Phys Ther. 2001;81(10):1629-1640

This reviewer is Board certified in Physical Medicine & Rehabilitation (1979). The physician providing this review is a Diplomate, American Academy of Physical Medicine and Rehabilitation; and Diplomate, American Board of Electrodiagnostic Medicine. This reviewer is a member of the American Spinal Injury Association, American Academy of Physical Medicine and Rehabilitation, State Academy of Physical Medicine and Rehabilitation, and State Medical Society. This reviewer has held various academic positions, is currently an Adjunct Associate Professor, and has authored numerous publications. The reviewer has additional training in Acupuncture. This reviewer is licensed to practice in four states and has been in practice since 1978.

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.

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Case Analyst: Stacie S ext 577