



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

<b>Type of Requestor:</b> ( X ) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address: Southeast Health Services P O BOX 453062 Garland, Texas 75045	MDR Tracking No.: M5-07-0588-01 (current MDR #) M5-07-0344-01 (former MDR #) M4-06-6887-01 (former MDR #)
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: ACE Fire Underwriters Insurance Company Rep Box # 15	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

#### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: Per the Table of Disputed Services "Please see the attached letter of medical necessity for services provided to this patient."

Principle Documentation:

1. DWC 60/Table of Disputed Services
2. CMS 1500's
3. Explanation of Benefits

#### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: "There is simply no medical documentation to substantiate the medical necessity for the treatments provided by Requestor. In conclusion, the Requestor should not be entitled to any reimbursement for the disputed treatments or services as they failed to provide any documentation to support the medical necessity of the services."

Principle Documentation: Response to DWC 60

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Amount Due
06-28-05 to 07-18-05	99211, 97110-59, 97039, 97140-59, 97018 and 99213	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
<b>TOTAL DUE</b>			<b>\$0.00</b>

#### 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, Medical Dispute Resolution has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained fee issues that were not addressed by the IRO and will be reviewed by Medical Dispute Resolution.

Dates of service 06-20-05 through 06-27-05 were not timely filed per Rule 133.308(e)(1) and will not be a part of the review.

On 01-16-07, Medical Dispute Resolution 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.

The Respondent filed a PLN11 on 07-20-05 denying diagnosis 354.0 (carpal tunnel syndrome) as related to the injury. The Respondent limited the compensable injury to right hand/wrist tenosynovitis. The Requestor billed for the compensable body part with diagnosis 727.00 (unspecified synovitis and tenosynovitis), therefore, the dispute went forward for IRO review and review by Medical Dispute Resolution.

CPT codes 99211, 97140-59 and 97018 billed for date of service 07-19-05 were denied by the Respondent with denial code "42" (charges exceed our fee schedule or maximum allowable amount). The explanation of benefits provided by the Respondent reflected payment in the amount of \$70.85. The Requestor was contacted via telephone on 02-14-06 regarding payment and stated that no payment had been received. The Respondent was contacted on 03-12-07 and was unable to provide payment information i.e. copy of cancelled check(s). Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$28.28, \$34.16 and \$8.41** respectively for a total reimbursement of **\$70.85**.

An explanation of benefits submitted by the Respondent for CPT code 97110-59 billed for date of service 07-19-05 reflected that payment in the amount of \$72.00 had been made to the Requestor. The Requestor was contacted via telephone on 02-14-06 regarding payment and stated that no payment had been received. The Respondent was contacted on 03-12-07 and was unable to provide payment information i.e. copy of cancelled check. Reimbursement is recommended per Rule 134.202(d)(2) in the amount of **\$72.00 (1 unit @ \$26.00 X 2 units)**.

#### **PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. 133.308, 134.1 and 134.202  
Texas Labor Code, Sec. 413.031 and 413.011 (a-d)

#### **PART VII: DIVISION FINDINGS 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 \$142.85. 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 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 Order by:

03-15-07

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Typed Name

\_\_\_\_\_  
Date of Findings and 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 3/5/07**

TDI-WC Case Number:	
MDR Tracking Number:	M5-07-0588-01
Name of Patient:	
Name of URA/Payer:	Southeast Health Services
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Bryan Weddle, DC

February 27, 2007

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

### DOCUMENTS REVIEWED

Notification of IRO Assignment  
Table of Disputed Services  
Downs & Stanford, medical review request.  
Employer's First Report of Injury,  
Medical Reports, James Lowell, MD, Concentra  
Physical Therapy Reports, Grace Miller, LPT, Concentra  
Medical Reviews, Thomas Diliberti, MD, orthopedics  
Medical Reports, Ranil Ninala, MD  
Electrodiagnostic Reports, Ranil Ninala, MD  
Medical Reports, Duc P. Vo, MD, orthopedics  
Unsigned Notes & Reports, Liberty Healthcare  
Chiropractic Reports & Notes, Bryan Weddle, DC  
Medical Reports, Charles Willis, MD  
Notice of Disputed Benefits, Sedgwick

Designated Doctor Evaluation, G. Peter Foux, MD, physical medicine  
Medical Peer Review, Byron Stain, MD, physical medicine

### CLINICAL HISTORY

Based on materials provided for review, it appears that this patient reports an injury to his hands while operating a high pressure hose on or about \_\_\_\_\_. He initially presented to Concentra Medical Center and was evaluated by James Lowell, MD for tenosynovitis of the hand/wrist. The patient was provided with medications and underwent multiple sessions of physical therapy. Physical therapy notes from 04/18/05 suggest that the patient undergoes active ROM activities, therapeutic exercise, and paraffin bath. The patient was later referred for electrodiagnostic tests with Dr. Ranil Ninala suggesting mild sensory median neuropathy. An orthopedic assessment with is made with a Duc Vo, MD and was again found with tendonitis, , ulnar nerve neuritis and possible carpal tunnel (atypical). The patient also undergoes injections with Dr. Vo and continues with braceing and anti-inflammatory medication. The patient appears to change treatment facilities and doctors to Liberty Healthcare and Bryan Weddle some time between 06/07/05 and 06/20/05. Dr. Weddle appears to continue the patient with therapeutic exercise, myofascial release and LSR cold laser therapy. The patient is then referred to Charles Willis, MD, for another medical evaluation on 06/21/05 and is found with carpal tunnel syndrome with myofascial pain. The patient is given Rx Neurontin for neuropathic pain and continued with therapy with Dr. Weddle. On 07/07/05, the patient is seen for designated doctor evaluation with Peter Foux, MD, and is found not to have carpal tunnel syndrome but to have diffuse wrist arthralgia aggravated with movement, compression and inflammation and is not found to be a surgical candidate. MMI is established 07/07/05 with 2% WP impairment levels. Chiropractic treatment with multiple modalities and activities continued through 07/19/05. Brief chiropractic daily notes and super bills are provided, but no specific therapy notes are provided for review.

### REQUESTED SERVICE(S)

Manual therapy (97140), therapeutic exercise (97110-59), office visits (99211/99213), paraffin bath (97018) and unlisted modality, (LSR/LLLT) cold laser therapy (97039) for dates of service 06/28/05 – 07/18/05.

### DECISION

Denied.

### RATIONALE/BASIS FOR DECISION

Chiropractic documentation **does not support** medical necessity for this ongoing therapy (97140, 97110, 99211, 99213, 97018, and 97139) performed from 06/28/05 to 07/18/05. This treatment appears to be largely a duplication for therapy already performed, and no specific chiropractic therapy reports are provided suggesting exactly how this therapy is performed and for what specific purpose(s). In addition, working diagnosis does not appear uniformly confirmed by available medical assessments, specialty consultations, and objective diagnostic measurements.

Given the equivocal or negative outcomes from a significant number of randomized clinical trials, it must be concluded that the body of evidence does not allow conclusions other than that the treatment of most pain syndromes with low level laser therapy provides at best the equivalent of a placebo effect. None of the studies compared LLLT to any of the current accepted conservative treatments for the conditions studied. In addition, data from larger randomized clinical trials comparing LLLT to standard medical and surgical treatment are necessary in order for any differences in outcomes to reach statistical significance so that conclusions can be reached concerning the overall effect of LLT on health outcomes.

Naeser MA, Hahn KA, Lieberman BE, Branco KF. Carpal tunnel syndrome pain treated with low-level laser and microampere transcutaneous electric nerve stimulation: A controlled study. *Arch Phys Med Rehabil* 2002;83(7):978-88

Irvine J, Chong SL, Amirjani N et al. Double blind randomized controlled trial of low-level laser therapy in carpal tunnel syndrome. *Muscle Nerve* 2004;30:182-87

Bakhtiary AH, Rashidy-Pour A. Ultrasound and laser therapy in the treatment of carpal tunnel syndrome. *Aust J Physiother* 2004;50:147-51

Lagan KM, McKenna T Witherow A, et al. Low-intensity laser therapy/combined phototherapy in the management of chronic venous ulceration: A placebo-controlled study. *J Clin Laser Med Surg* 2002;30(3):109-16

Gur A, Karakoc M, Nas K et al. Efficacy of low level laser therapy in fibromyalgia: a single-blind, placebo-controlled trial. *Lasers Med Sci* 2002;17(1):57-61

Altan L, Bingol U, Aykac M. Investigation of the effect of GaAs laser therapy on cervical myofascial pain syndrome.

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, 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.

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