



Texas Department of Insurance, Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL NECESSITY DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Dr. Suhail Al-Sahli 1210 A Nasa Rd. 1 Houston, Texas 77058	MFDR Tracking #: M5-08-0059-01 Previous #: M5-05-2062-01
	DWC Claim #:
	Injured Employee:
	Date of Injury:
Respondent Name and Box #: CLEAR CREEK ISD BOX 21	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "We have appealed to collect these charges from the insurance carrier, but the carrier has failed to provide us with proper explanation for not paying for these services."

Principal Documentation:

1. DWC 60 package
2. Total Amount Sought - \$8,428.89
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "The bills from 8-6-04 – 12-6-04 were denied with exception code (V), based upon TWCC Rule 133.301 subsection (9)."

Principal Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS – FEE ISSUES – dates of service 6-10-04 through 7-26-04 only

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
6-10-04 – 7-26-04	97110 (\$35.91 x 7 units)	R (880-105)	1, 2, 3, 4	\$251.37
6-10-04 – 7-26-04	98940-25 (\$32.84 x10 units)	R (880-105)	1, 2, 3, 4	\$328.40
6-10-04 – 7-26-04	97112, 99212	R (880-105)	1, 2, 5	\$0.00
Total Due:				\$579.77

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

1. The Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective August 1, 2003, set out the reimbursement guidelines for the fee issues from 6-10-04 through 7-26-04. These services were denied by the Respondent with reason code "R (880-105) - Extent of injury, denied per insurance: service does not appear to be related to the Workers' Comp injury/illness."
2. The Requestor billed with the Diagnostic codes of 840.0 - ACROMIOCLAVICULAR SPRAIN/STRAIN and 726.3 - ENTHESOPATHY OF ELBOW REGION. The compensable injury is to the elbow and shoulder. The services from 6-10-04 through 7-26-04 are compensable and will be reviewed per Rule 134.202(b).
3. Per review of Box 32 on CMS-1500, zip code 77058 is located in Harris County. The maximum reimbursement amount, under Rule 134.202(b), is determined by locality.
4. Per Rule 134.202(d) "reimbursement shall be the least of the (1) MAR amount as established by this rule; (2) health care provider's usual and customary charge; or (3) health care provider's workers' compensation negotiated and/or contracted amount that applies to the billed service(s)." The lesser of these amounts was the usual and customary charge.
5. Per Rule 134.202(b) CPT codes 97112 and 99212 CPT are considered per Rule 134.202(b) to be component procedures of CPT code 98940-25 which was billed on the same date of service. A modifier is allowed to differentiate between the services billed. The Requestor did not bill with a modifier. No reimbursement recommended.

All services from 8-06-04 through 12-06-04 (CPT codes 99212, 99213-25, 98940-25, 98941, 98942, 98943, 97110, 97012, 97112, 97032, 97124, 97140, 97116 and 97035) were denied by the Respondent for medical necessity. 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. No reimbursement recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code Sections 133.308, 134.1, 134.202
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement for fee issues. The Requestor is not entitled to a refund of the IRO fee for the services involved in this dispute. The Division hereby **ORDERS** the Carrier to - remit to the Requestor the amount of \$579.77 plus applicable accrued interest per Division Rule 134.803, due within 30 days of receipt of this Order.

ORDER:

		2-13-08
_____ Authorized Signature	_____ Medical Fee Dispute Resolution Officer	_____ Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

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

Austin, Texas 78735

Phone: 512-288-3300 FAX: 512-288-3356

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-08-0059-01
Name of Patient:	_____
Name of URA/Payer:	Suhail Al Sahli, DC
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Suhail Al Sahli, DC

December 20, 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 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: Texas Workers' Compensation Commission

ITEMS REVIEWED

1. MRI report, left shoulder (09/12/02);
2. Electrodiagnostic study, Vachhani, DC (10/29/02);
3. Orthopedic consult (12/20/02) with subsequent operative report, Elbaz (4/2/03);
4. Psychological consult, Meltzer, PhD (8/6/03);
5. Electrical stimulation machine usage report, RS medical (07/08/03-07/31/03); FCE , Seth, OTR (07/21/07);
6. Work Hardening notes (07/23/03-09/03/03), CPM notes (11/4/03 - 12/18/03);
7. Daily soap notes, Sahli, DC (11/15/02 - 12/6/04). Pain management assessment/treatment note Saqer, MD (5/7/04, then monthly through 12/10/04);
8. Respondents (carrier) rationale for denial;
9. IRO decision 7/2/04; and
10. Peer reviews Canard, DC (10/30/03 and 12/10/04).

CLINICAL HISTORY

Patient, a 67-year-old female who was 63 at the time of disputed services, sustained injuries to her left shoulder, elbow, left hip and lower back after a slip and fall on a wet floor, landing striking her left side. She underwent chiropractic care with Dr. Al Sahli. MRI of left shoulder 9/4/02 showed a complete tear of the supraspinatus tendon, effusion in the glenohumeral joint with hypertrophic changes around the acromioclavicular joint. Electrodiagnostic studies 10/29/02 unremarkable. Patient progressed to surgery 04/02/03 with Dr. Elbaz, included left rotator cuff repair, subacromial decompression with partial claviclectomy, along with an open epicondylar release of the left elbow. Documentation suggests patient underwent a work hardening program between 7/21/03-8/22/03, followed by a chronic pain program (11/4/03-1/13/04). Patient placed at MMI on 12/22/03 with a 15% whole person impairment rating per designated doctor. IRO decision reviewing care rendered between 7/31/03-11/18/03, opined that the care was unnecessary (as pertained to postoperative care to the shoulder and elbow), but determined that the work hardening was medically necessary. Peer reviews Dr. Canard found that care was excessive and not medically necessary. Subsequent treatment notes available starting 3/26/04 indicate ongoing treatment related to symptoms of mild lower back pain, mild left hip pain, mild restricted left shoulder motion and mild pain in the left forearm. Pain management note of 5/7/04 relates a pain level of 6/10, patient in no need pain medication, having some difficulty sleeping. Vicodin then added to medication regime on 6/4/04. Monthly follow-ups indicate pain under good control, 9/10/04 patient quoted as handling ADLs without any problems. Throughout the treatment notes, all symptoms seem essentially unchanged, clinical assessment (Dr. Sahli) is that the patient is essentially the same through most of the notes. No progression / response / deviation to the program is indicated by the documentation. The patient appeared to be suffering minimal subjective complaints with few objective findings identified and with no documented indication that continued care is providing any dramatic change to the clinical picture.

REQUESTED SERVICE(S)

Retrospective medical necessity of office visits (99212, 99213); chiropractic manipulation (98940, 98941, 98942); therapeutic exercises (97110); mechanical traction (97012); neuromuscular reeducation (97112); attended electrical stimulation (97032); massage (97124); manual therapy techniques (97140); gait training (97116); ultrasound (97035). Dates of service: 8/6/04-12/6/04.

DECISION

Denied

RATIONALE/BASIS FOR DECISION

The standard of medical necessity in Workers Comp, according to the Texas labor code 408.021 (entitlement to medical benefits) is that an employee who sustained a compensable injury is entitled to all healthcare reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to healthcare that (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment.

Unfortunately, at a point some two years post injury and 15 months post surgery, there is absolutely no rationale offered as to why such an intensive ongoing treatment regime would be necessary, especially considering that the patient had already progressed through a work hardening and chronic pain management program, and had been determined at MMI. In order for a patient to be receiving ongoing care in such an undeviating fashion, there needs to be some supporting evidence as to why this particular care falls outside of the "average" expected care time frame that is usually attributed to such injuries. No indication for this care is present.

In order to receive care that is reimbursable, history and examination should identify and document risk factors defending further care necessity. Unfortunately, in this case no progression / response / deviation to the program is indicated by the documentation to support continuing care. The records all appear to be of the computerized "canned" variety. They are repetitious, contain minimally clinically useful information and do not show significant progress / substantive change in treatment. Unfortunately this provides precious little clinical insight as to the patient's status, progression or improvement/response to care.

The supplied documentation and clinical record as a whole demonstrates a paucity of information in terms of reasonable outcome assessment measures, or of any level of descriptive, quantifiable objective data subsequently per date of encounter. The available records did not demonstrate any degree of objective improvement with care. Any continuing care is not warranted unless justified by appropriate clinical evidence of deterioration from an established baseline with subsequent necessity determined by measuring standardized and objective standards of improvement demonstrating the requirement for continued, ongoing care. Continuing care therefore appears to be beyond current clinical standards and does not appear to satisfy any of the above three mandates of medical necessity.

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

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Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell