



**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:  Central Dallas Rehab 3500 Oak Lawn, Suite 380 Dallas, TX 75219	MDR Tracking No.: M5-04-2062-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  Continental Casualty Company, Box 47	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

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

Documents included TWCC 60 form, Explanations of Benefits, medical documentation and CMS 1500's. Position summary states, "These services are for evaluation and management consultative services. Since our patient has not reached point of MMI, it is necessary for the treating doctor to monitor his patient's progress toward functional recovery and within the scope of responsibility for the treating doctor to charge for these office evaluations."

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

Documents included medical documentation. Position summary states, "Because the physical medicine treatment in dispute was not medically necessary and did not meet the requirements for reimbursement under the Medical Fee Guideline, the Provider is not entitled to reimbursement."

**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)
8-1-03 – 12-31-03	CPT codes 97110, 99211, 99212, 95851, 95831	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0

**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 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 8-22-05 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.

Regarding CPT code 99211 on 8-1-03, 8-8-03, 8-13-03, 8-21-03 and 8-27-03: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). Recommend reimbursement of \$133.82 (\$26.50 X 2 DOS plus \$26.94 X 3 DOS).

Regarding HCPCS code L1810 on 11-26-03: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). Recommend reimbursement of \$82.55.

Regarding CPT code 99212 on 11-26-03, 12-24-03, 12-29-03 and 12-30-03: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). Recommend reimbursement of \$188.92 (\$47.23 X 4 DOS).

Regarding CPT code 95851 on 12-30-03: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). Recommend reimbursement of \$35.78.

Regarding CPT code 97110 on 11-26-03, 12-24-03, 12-29-03 and 12-30-03: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). The requestor did document face to face contact and a description of the injury and why the exercise was necessary. Recommend reimbursement of \$544.80 (\$136.20 X 4 DOS).

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

28 Texas Administrative Code Sec. 133.308 and 133.307(e)

**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 requestor is entitled to reimbursement in the amount of \$985.87. 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.

Findings and Decision and Order by:

Donna Auby

9-29-05

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.**

May 14, 2004

**NOTICE OF INDEPENDENT REVIEW DECISION**

**RE: MDR Tracking #: M5-04-2062-01**  
**TWCC #:**  
**Injured Employee:**  
**Requestor:**  
**Respondent:**  
**----- Case #:**

----- has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ----- IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ----- for independent review in accordance with this Rule.

----- has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ----- external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ----- chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ----- for independent review. In addition, the ----- chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 31 year-old female who sustained a work related injury on ----- . The patient reported that while at work she was hit in the left knee with a pallet. The patient was

initially treated with medications, injections and physical therapy. A MRI of the left knee performed on 1/11/02 was reported to have shown a grade III tear of the periphery of the body of the lateral meniscus as well as osteochondral injury and proximal tibial enchondroma. On 4/2/02 the patient underwent arthroscopic surgery of the left knee followed by a course of physical therapy. The patient was subsequently returned to work. However the patient only completed two days of duty due to increased left knee pain and swelling. On 9/12/02 the patient began treatment with her treating chiropractor. The patient was treated with physical therapy and chiropractic treatments.

### Requested Services

Therapeutic exercises, office visits, ROM measurements, muscle testing (manual), from 9/5/03 through 11/24/03, 11/28/03 through 12/23/03 and date of service 12/31/03.

### Documents and/or information used by the reviewer to reach a decision:

#### *Documents Submitted by Requestor:*

1. Letter 1/7/03
2. SOAP notes 8/1/03 – 1/21/04

#### *Documents Submitted by Respondent:*

1. MRI report 1/11/02
2. Letter 4/15/04
3. Progress notes 4/4/03 – 7/25/03

### Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is upheld.

### Rationale/Basis for Decision

The ----- chiropractor reviewer noted that this case concerns a 31 year-old female who sustained a work related injury to her left knee on ----- . The ----- chiropractor reviewer also noted that on 4/2/02 the patient underwent arthroscopic surgery of the left knee followed by a course of physical therapy. The ----- chiropractor reviewer further noted that the patient began a second course of treatment that consisted of physical therapy and chiropractic treatments. The ----- chiropractor indicated that this patient had extensive conservative care before and after surgical intervention with no reported improvement. The ----- chiropractor reviewer explained that the patient is morbidly obese and has signs of osteo arthritis in the injured knee that creates a complicating factor. The ----- chiropractor reviewer noted that the patient was found to be at maximum medical improvement with a 3% impairment on 6/27/03. The ----- chiropractor reviewer explained that treatment after this time is not expected to produce any improvement. The ----- chiropractor reviewer also explained that treatment after this time was extensive

without any change in pain from 9/12/03 through 12/31/03. Therefore, the ----- chiropractor consultant concluded that the therapeutic exercises, office visits, ROM measurements, muscle testing (manual), from 9/5/03 through 11/24/03, 11/28/03 through 12/23/03 and date of service 12/31/03 were not medically necessary to treat this patient's condition.

Sincerely,

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State Appeals Department