

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP () IE () IC	Response Timely Filed? (X) Yes () No
Requestor's Name and Address Rehab First PO Box 453062 Garland TX 75045	MDR Tracking No.: M5-05-2319-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Rep Box # 54 Texas Mutual Insurance	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
4-28-04	11-15-04	99211, 97110, 95904, 97530, G0283, 97140-59, 99213-25, 99214, 97035, 95903, 95934	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

PART III: 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 Commission Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Medical Review Division 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 the Medical Review Division.

On 5-19-05 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.

Code 99213-25 billed on 5-3-04, 7-26-04, 9-9-04 as listed on the table of disputed services did not have an EOB submitted by either party. The requestor submitted convincing evidence of carrier receipt of request for reconsideration. Therefore, this review will be per the 2002 MFG. Requestor billed with modifier -25 that indicates a separate identifiable E/M service. Therefore, recommend reimbursement of $\$54.59 \times 125\% = \$68.24 \times 3 \text{ days} = \204.72 .

97150 billed for date of service 5-13-04 was denied as YN, documentation does not substantiate the service and 9*JF, documentation does not indicate why the professional skills of a licensed health care provider are required. Requestor did not submit documentation to support services billed. Therefore, no reimbursement recommended.

99080-73 billed for date of service 5-21-04 was denied as F,86 – provider billed for a work status report on a subsequent date of service. Per the bills, the requestor did not submit a work status report on a subsequent date of service. Therefore, recommend reimbursement of \$15.00 per rule 129.5.

99080-73 billed for dates of service 7-14-04 and 8-20-04 was denied as F, TD – work status report was not properly completed or submitted in excess of the filing requirements. denied per rule 129.5. The requestor did not submit copies of

the TWCC-73; therefore, filing requirements could not be verified. No reimbursement recommended.

99211 billed on date of service 10-18-04 was paid @ \$24.44 with denial reason F,790 – charge reduced per Texas MFG. The requestor is seeking an additional \$3.42. The MAR is $22.29 \times 125\% = \$27.86$. Recommend additional reimbursement of \$3.42.

PART IV: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to reimbursement for the medical necessity issues involved in this dispute and is not entitled to a refund of the paid IRO fee. The Division hereby **ORDERS** the insurance carrier to remit the amount of \$223.14 for the fee issues plus all accrued interest due at the time of payment to the Requestor within 20 days of receipt of this Order.

Ordered by:

8-30-05

Authorized Signature

Typed Name

Date of Order

PART V: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____

PART VI: YOUR RIGHT TO REQUEST A HEARING

YOUR RIGHT TO REQUEST A HEARING

If you are unhappy with all or part of this decision, you have the right to appeal the decision. Those who wish to appeal decisions that were issued during the month of August 2005, should be aware of changes to the appeals process, which take effect September 1, 2005.

House Bill 7, recently enacted by the 79th Texas Legislature, provides that an appeal of a medical dispute resolution order that is not pending for a hearing at the State Office of Administrative Hearings (SOAH) on or before August 31, 2005 is not entitled to a SOAH hearing. This means that the usual 20-day window to appeal to SOAH, found in Commission Rule 148.3, will be shortened for some parties during this transition phase. If you wish to seek an appeal of this medical dispute resolution order to SOAH, you are encouraged to have your request for a hearing to the Commission as early as possible to allow sufficient time for the Commission to submit your request to SOAH for docketing. A request for a SOAH hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas 78744 or faxed to 512-804-4011. A copy of this Decision should be attached to the request.

Beginning September 1, 2005, appeals of medical dispute resolution 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.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

IRO America Inc.

An Independent Review Organization

(IRO America Inc. was formerly known as ZRC Services Inc. DBA ZiroC)

7626 Parkview Circle

Austin, TX 78731

Phone: 512-346-5040

Fax: 512-692-2924

Amended Decision 8/17/05

August 8, 2005

TWCC Medical Dispute Resolution

Fax: (512) 804-4868

Patient: _____
TWCC #: _____
MDR Tracking #: M5-05-2319-01
IRO #: 5251

IRO America Inc. (IRO America) has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission (TWCC) has assigned this case to IRO America for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

IRO America 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.

The independent review was performed by a matched peer with the treating doctor; the Reviewer is a credentialed Panel Member of IRO America's Medical Knowledge Panel who is a licensed Provider, board certified and specialized in Chiropractic care. The reviewer is on the TWCC Approved Doctor List (ADL).

The IRO America Panel Member/Reviewer is a health care professional who has signed a certification statement stating that no known conflicts of interest exist between the Reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to IRO America for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

RECORDS REVIEWED

Notification of IRO assignment, information provided by Requestor, Respondent, and Treating Doctor(s) including:

1. Medical Dispute Resolution Request, 5-17-05.
2. Table of Disputed Services, 4-28-04 through 11-15-04.
3. Explanation of Benefits, 4-28-04 through 11-15-04.
4. Query of Treatments, 3-28-04 through 10-7-04.
5. Medical Records for IRO Assignment from Rehab First.
6. Operative report, 3-30-04.
7. Medical reports from Gregg Shalan, M.D., 3-31-04 and 3-38-04.
8. Medical reports from Joseph Tejan, M.D., 4-7-04 through 1-6-05.
9. Reports from Bala Giri, M.D., 4-14-04 through 9-22-04.
10. Neuro-Selective CPT Laboratory report, 4-28-04.
11. Lumbar x-ray report, 5-5-04, left rib x-ray report, 5-11-04, and lumbar x-ray report, 6-7-04.
12. Patient Comfort Assessment Guide, 5-4-04 through 5-13-04.
13. Right elbow and forearm x-ray report, 8-11-04, lumbar x-ray report, 9-3-04, right elbow x-ray report, 7-26-04, right elbow x-ray report, 10-6-04, and right elbow x-ray report, 12-21-04.

14. Left knee MRI report, 4-28-04.
15. Behavioral documentation from PRISMA Behavioral Health Providers, 6-10-04 through 10-13-04.
16. Medical report from Lorraine Rudder, M.D., 7-26-04.
17. EMG/NCV report, 7-28-04.
18. FCE report, 10-13-04.
19. DD Evaluation by Floyd Columbus, M.D., 10-20-04.
20. TWCC-73s, 3-28-04 and 8-20-04.
21. Medical report from L.T. Johnson, M.D., 3-7-05.
22. Medical reports from Sybil Reddick, M.D., 4-22-04 through 2-3-05.
23. Therapeutic Exercise Logs from Rehab First, 4-27-04 through 2-7-05.
24. Impairment Rating by Sybil Reddick, M.D., 3-24-05.
- 25.

CLINICAL HISTORY

According to the records provided, the patient was working as a youth advocate when she was looking into the trunk of a car when her client back over her and pinned her under the car. The patient sustained a complex fracture of the right elbow, compression fractures to L2 and L4, and a medial collateral ligament sprain in the left knee. The patient had some temporary confusion and memory loss resulting in a MRI of the brain that was normal. The patient was given a TLSO brace for her L2 and L4 compression fractures. The documentation from Dr. Giri indicated she was neurologically stable in regards to motor, sensory, and reflex testing and had no lower extremity paresthesias.

Repeat x-rays did not reveal any change in the patient's compression fractures.

On 3-30-04, Dr. Tejan performed an open reduction internal fixation surgery performed to the elbow. Postoperatively, the elbow wound healed nicely and there was no evidence of infection. Post-operative x-rays demonstrated normal appearing hardware and subsequent x-rays did not reveal any change from prior exams. The patient was given Hydrocodone and Bextra.

The patient was managed medically by Sybil Reddick, M.D. from 4-22-04 through 3-24-05. The patient was seen approximately 1 time per week through 10-29-04 and approximately 1 time every second week through 3-24-05.

The patient participated in therapeutic exercise at Rehab First from 4-27-04 through 2-7-05. The rehabilitation was instructed by Jeff Tamplen, exercise physiologist. A physical therapist and/or chiropractor were not involved in the rehabilitation services. Apparently, Dr. Reddick supervised the rehabilitation.

Left knee MRI dated 4-28-04 demonstrated a contusion in the lateral femoral condyle, a great II tear of the medial collateral ligament, and effusion in the knee joint.

Behavioral treatment was performed at the PRISMA Behavioral Health Providers clinic from 6-10-04 through 10-13-04. EMG/NCV testing dated 7-28-04 demonstrated findings consistent with a right ulnar neuropathy at the elbow.

FCE dated 10-13-04, after approximately 6 months of physical therapy, indicated the patient had the ability to perform at a sedentary physical demand level with restrictions. A Designated Doctor Evaluation was performed by Floyd Columbus, M.D. on 10-20-04. He did not believe the patient was at maximum medical improvement and possibly required hardware removal in the elbow.

Eventually, the hardware was removed.

On 3-7-05, the patient was evaluated by L.T. Johnson, M.D. for ongoing knee pain. Diagnosis was sprain/strain, contusion, and dysfunction. He did not believe the patient was a surgical candidate.

The rehabilitation services at Rehab First between 4-28-04 and 2-7-05 included one hour of one-on-one based therapeutic exercise, one hour of one-on-one based therapeutic activities, 1-2 units of electrical stimulation, manual therapy techniques, and ultrasound. Dr. Reddick billed evaluation and management services one time per week from 4-28-04 through 10-29-04.

On 3-24-05, Dr. Reddick performed an Impairment Rating. The patient was assigned 14% WPI.

The insurance carrier denied all services from 6-30-04 through 10-11-04. The insurance company paid for some active based therapy from 10-15-04 through 11-15-04.

DISPUTED SERVICE(S)

Under dispute is the retrospective medical necessity of CPT codes 99211, 99213-25 office visits, 97110 therapeutic exercise, 97530 therapeutic activities, G0283 electrical stimulation, 97140-59 manual therapy techniques, 97035 ultrasound, 95903 and 95904 nerve conduction, 95934 H reflex for dates of service 4-28-04 through 11-15-04. And code 99214 for the date 8/20/04.

DETERMINATION/DECISION

The Reviewer agrees with the determination of the insurance carrier.

RATIONALE/BASIS FOR THE DECISION

In the reviewer's medical opinion, the evaluation and management codes 99211 and 99213 were billed in excess. The health-care provider initially was billing the services at a frequency of one time per week for approximately 6 months. In the Reviewer's medical opinion, and evaluation and management codes were not reasonable greater than one time per month.

The therapeutic exercise and therapeutic procedures were billed at an intensity of four units each for a total time 2 hours. In the Reviewer's medical opinion, this is excessive. In order to support the billing of one-on-one based therapeutic exercise, the documentation must clearly indicate the therapeutic exercise program was progressed to require one-on-one supervision. One-on-one supervision is not required for aerobic exercise such as biking and one-on-one guidance is not necessary while the patient performs existing exercises. The patient's exercise program was monotonous and very similar from day to day. The Official Disability Guidelines indicate olecranon fractures, grade II medial collateral ligament tears, and thoracic compression fractures will require approximately 8-10 weeks of active based rehabilitation, therefore the treatment beyond this 10 week timeframe extends far beyond guideline parameters without medical justification. Two units of one-on-one based therapeutic exercise for the initial 8-10 weeks would certainly be reasonable, however the documentation does not support one-on-one based care beyond this timeframe.

Passive modalities including electrical stimulation, manual therapy techniques, and ultrasound have not been shown to provide therapeutic benefit in the treatment of knee pain, elbow pain, thoracic pain, or lumbar pain greater than eight weeks. For this reason, passive care should be time-limited. Passive procedures for the initial 8-12 weeks would certainly be reasonable. After this time, emphasis of treatment should be on active care. If the patient needed some pain control measures, a home ice pack application or a home TENS unit rental would be more cost-effective. Certainly, ongoing electrical stimulation, manual therapy techniques, and ultrasound would not produce any additional therapeutic benefit greater than or equal to what would be experienced with a home exercise program.

In the Reviewer's medical opinion, the documentation does not support the H reflex and NCV testing. The patient complaints and physical examination findings from multiple providers did not indicate there was any evidence of upper extremity paresthasias consistent with cervical radiculopathy or peripheral neuropathy to support the electrodiagnostic testing. Consistent complaints and consistent physical examination findings do not indicate there was evidence of ulnar neuropathy. The findings suggesting an ulnar neuropathy are likely an incidental finding and unrelated to the compensable injury.

Lastly, the documentation does not indicate the treatment performed at Rehab First enhanced the ability of the patient to return to work, reduced the need for health-care services, or objectively promoted recovery at a faster rate than the natural history. The most meaningful outcome measurement tool available is the rate of return to work. This patient's job required a sedentary physical demand level. Despite six months of physical therapy to include two hours of active based exercise, the patient was still functioning below the sedentary physical demand level according to the functional capacity evaluation in October of 2004. If returning to work is the most meaningful outcome measurement tool, the documentation clearly indicates the treatment did not enhance the ability of this patient to return to work.

There is strong medical evidence indicating over-treatment and over-investigation commonly contribute to chronic pain and a disability mindset. This patient was taken off work and participated in excessive amount of physical therapy to include two hours of one-on-one based care from April through November of 2004.

Screening Criteria

General:

In making his determination, the Reviewer had reviewed medically acceptable screening criteria relevant to the case, which may include but is not limited to any of the following: Evidence Based Medicine Guidelines (Helsinki, Finland); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Texas Chiropractic Association: Texas Guidelines to Quality Assurance (Austin Texas); Texas Medical Foundation: Screening Criteria Manual (Austin,

Texas); Mercy Center Guidelines of Quality Assurance; any and all guidelines issued by TWCC or other State of Texas Agencies; standards contained in Medicare Coverage Database; ACOEM Guidelines; peer-reviewed literate and scientific studies that meet nationally recognized standards; standard references compendia; and findings; studies conducted under the auspices of federal government agencies and research institutes; the findings of any national board recognized by the National Institutes of Health; peer reviewed abstracts submitted for presentation at major medical associates meetings; any other recognized authorities and systems of evaluation that are relevant.

CERTIFICATION BY OFFICER

IRO America has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. IRO America has made no determinations regarding benefits available under the injured employee's policy.

As an officer of IRO America Inc., I certify that there is no known conflict between the Reviewer, IRO America and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

IRO America is forwarding by mail or facsimile, a copy of this finding to the TWCC, the Injured Employee, the Respondent, the Requestor, and the Treating Doctor.

Sincerely,

IRO America Inc.

A handwritten signature in black ink, appearing to read "Dr. Roger Glenn Brown", written over a horizontal line.

Dr. Roger Glenn Brown

President & Chief Resolutions Officer