

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 Alpine Healthcare, L. P. 1621 N. Main Ave. Ste 5 San Antonio, TX 78211	MDR Tracking No.:
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address TX Mutual Insurance Company, Box 54	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		
6-23-04	7-2-04	CPT code 97035, 97110, 99213, 97140, 99199	<input checked="" type="checkbox"/> Yes <input 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 **prevailed** on the disputed medical necessity issues. The total amount due for medical necessity services is \$473.35.

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. The ultrasound, therapeutic exercise, offices visits and unlisted procedures rendered from 6-23-04 through 7-2-04 services were found to be medically necessary. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 6-13-05 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.

CPT code 97014 is not a valid code per the 2002 MFG and will not be a part of this review.

CPT code 95831 on 7-2-04 was denied as "YG – Reimbursement for this procedure is included in the basic allowance for another procedure." Per the 2002 MFG CPT code 95831 is considered to be a component of CPT code 99213. **The services will not be paid separately.**

CPT code 96004 on 7-2-04 and 6-25-04, were denied as "YG – Reimbursement for this procedure is included in the basic allowance for another procedure." .” Per the 2002 MFG this CPT code is not considered to be a component of any of the other codes billed on that date of service. **Recommend reimbursement of \$287.58 (\$143.79 MAR X 2 DOS).**

CPT code 99199 on 6-25-04, 6-30-04 and 7-2-04 were denied as "YF-Reduced or denied in accordance with the appropriate fee guideline." When reducing the services for which the Commission has not established a maximum allowable reimbursement, per Rule 133.307(g)(3)(D), the Requestor is required to discuss, demonstrate and justify that the payment being sought is a fair and reasonable rate of reimbursement. The Requestor has not provided sample EOBs or other evidence that the fees billed are for similar treatment of injured individuals and that reflect the fee charged to and paid by other carriers. **Recommend no reimbursement.**

CPT code 99199 on 6-23-04 and 6-28-04 were denied as "09-provider did not identify the service or materials supplied sufficiently." The requestor did not provide documentation to support delivery of services per Rule 133.307(g)(3)(A-F). **Recommend no reimbursement.**

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 entitled to a refund of the paid IRO fee in the amount of \$460.00. The Division hereby **ORDERS** the insurance carrier to remit the amount of \$760.93, plus all accrued interest due at the time of payment, to the Requestor within 20-days of receipt of this Order.

Ordered by:

Donna Auby

8-12-05

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

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.

ORIGINAL REVIEW COMPLETION DATE: JULY 1, 2005
AMENDED REVIEW COMPLETION DATE: JULY 8, 2005

TEXAS WORKERS COMP. COMISSION
AUSTIN, TX 78744-1609

CLAIMANT: ____
EMPLOYEE: ____
POLICY: M5-05-2415-01
CLIENT TRACKING NUMBER: M5-05-2415-01 5278

AMENDED REVIEW 08/11/05

Medical Review Institute of America (MRIoA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Workers Compensation Commission has assigned the above mentioned case to MRIoA for independent review in accordance with TWCC Rule 133 which provides for medical dispute resolution by an IRO.

MRIoA has performed an independent review of the case in question 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 TWCC approved doctor list (ADL). The reviewer has signed a statement indicating they have no known conflicts of interest existing between themselves and the treating doctors/providers for the patient in question or any of the doctors/providers who reviewed the case prior to the referral to MRIoA for independent review.

Records Received:

The following documents were presented and reviewed:

Records Received from the State:

Notification of IRO assignment dated 6/13/05, 7 pages

List of providers' names, addresses, city, state, zip codes, phone numbers dated 5/18/05, 3 pages

Explanation of benefit forms, dates of service 6/24/04 through 7/2/04, 10 pages

(continued)

Records Received from Dr. Sealy:

IRO statement dated 6/23/05, 1 page

MRI of left knee report dated 6/8/04, 1 page

Official Disability Guidelines dated 2004, 3 pages

Table of disputed services, dates of service 6/23/04 through 7/2/04, 2 pages

Clinical notes dated 6/23/04 through 7/2/04, 19 pages

Office notes dated 6/25/04 and 7/2/04, 3 pages

Muscle testing reports dated 6/25/04 7/2/04, 11 pages

Letter from Texas Worker's Compensation Commission dated 6/29/05, 1 page

Summary of Treatment/Case History:

The claimant was working for Renhill Staffing Services of Texas when he was involved in a work-related injury on _____. This patient was transporting gravel out of a ditch with a shovel and slipped, resulting in an injury sustained to the left knee. MR imaging of the left knee performed on 6/8/04 revealed pathology consistent with a lateral meniscus tear midzone and posterior horn. On 6/23/04 the claimant presented to the offices of Rita J. Sealy-Wirt, DC with a pain intensity 8/10 on VAS over the left knee. A controlled trial of rehabilitation applications was implemented from 6/23/04 through 7/2/04; the provider utilized passive and active physiotherapeutics.

Questions for Review:

Item in dispute: #97035 ultrasound, #97110 therapeutic exercise, #97140 manual therapy technique, #99213 office visits, and #99199 unlisted procedures. Dates of service in dispute: 6/23/04 through 7/2/04. Denied by carrier as not medically necessary.

Explanation of Findings:

This patient sustained a meniscus tear over the left knee in his _____ work related injury. It is clearly evident that a controlled trial of conservative application needs to be implemented to restore prior function and to rule in/out the patient as a candidate for invasive surgical correction of the left knee pathology.

Decision: There is no clear rationale presented to support the denial of the services rendered by the provider in the management of this claimant's work injury from 6/23/04 through 7/2/04. The provider is well within the standards set forth in the Official Disability Guidelines put forth by the Work Loss Data Institute. It is clear that the claimant has musculoskeletal pathology evident in the 6/8/04 MR of the left knee; a controlled trial of physical therapy applications is medically appropriate and reasonable. The provider has fully established necessity for the changes implemented in the management of this claimant's condition.

Conclusion/Decision to Certify:

There are no peer-reviewed, published guidelines that support the premise for the denial of the services rendered to this worker by the provider from 6/23/04 through 7/2/04. A controlled trial of physical therapy applications is medically appropriate and reasonable.

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References Used in Support of Decision:

American Academy of Orthopaedic Surgeons (AAOS) clinical guideline on knee injury: support document. 2001. 6 p.

Fritz, et al. MR imaging of meniscal and cruciate ligament injuries. Magn Reson Imaging Clin N Am, 2003 May; 11(2):283-93.

Knee.Work Loss Data Institute; 2003. 46 p.

Weiss CB, et al. Non-operative treatment of meniscal tears. J Bone Joint Surg Am. 1989 Jul;71(6):811-22.

The chiropractor providing this review received his degree in chiropractic in 2000. The reviewer is a member of the American College of Sports Medicine, the Meckenzie Institute, the Occupational Injury Prevention and Rehabilitation Society, the International Association of Rehabilitation Professionals and the National Safety Council. The reviewer is pursuing additional qualifications as a diplomate in rehabilitation. They are also pursuing Occupational Health and Safety Technologist certification in preparation for their Certified Safety Boards. The reviewer also works as a review doctor for their state workers compensation commission in the medical dispute resolution process.

MRIOA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the treating provider, payor and/or URA, patient and the TWCC.

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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