



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: Jack T. Barnett, D.C. 2215 Airline Drive Houston, Texas 77009	MDR Tracking No.: M5-05-2425-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Employers Insurance Company of Wausau Box 28	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Please be advised that Airline Chiropractic & Rehabilitation, P.A. files this Request for Medical Resolution.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No position statement available in file.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
05-21-04 to 07-07-04	97110 (4 units maximum), 97035, 97124, 99211 and G0283	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2,901.31
07-09-04 to 10-01-04	97110, 97035, 97124, A4556 AND g0283	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
05-21-04 to 10-01-04	98943	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
06-07-04 to 07-07-04	99214	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
06-21-04 to 06-21-04	E1399	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
06-29-04 to 06-29-04	99070	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

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 **majority** of 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 08-26-05, 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 97750-MT date of service 08-04-04 listed on the table of disputed services will not be a part of the review as the MT modifier is invalid for Medicare per Rule 134.202(b).

CPT code 99455-VR date of service 07-22-04 denied with denial code "V" (unnecessary medical treatment with peer review). Per Rule 134.202(6) code 99455-VR is a required report and not subject to an IRO review. Reimbursement is recommended in the amount of **\$50.00**.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, Rule 134.202(b) and Rule 134.202(6)

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 IRO fee. The Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute totaling \$2,951.31 and hereby **ORDERS** the insurance carrier to remit the appropriate amount for the services in dispute consistent with the applicable fee guidelines, plus all accrued interest due at the time of payment, to the Requestor within 30 days of this Order.

Findings and Decision and Order by:

Authorized Signature

Typed Name

Date of Decision 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.



7600 Chevy Chase, Suite 400
Austin, Texas 78752
Phone: (512) 371-8100
Fax: (800) 580-3123

NOTICE OF INDEPENDENT REVIEW DECISION

Date: August 23, 2005

To The Attention Of: TWCC
7551 Metro Center Drive, Suite 100, MS-48
Austin, TX 78744-16091

RE: Injured Worker: _____
MDR Tracking #: M5-05-2425-01
IRO Certificate #: IRO 5263

Forté has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractic reviewer who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- Requester's position statement
- Peer reviews
- Table of disputed services
- EOBs
- Designated doctor report
- Daily notes
- Exercise sheets
- Examination reports

Submitted by Respondent:

- Peer reviews
- Table of disputed services
- EOBs
- Designated doctor report
- Daily notes

- Exercise sheets
- Examination reports

Clinical History

According to the supplied documentation, the claimant sustained an injury on ___ when he fell sustaining an injury to his left wrist. He was seen at Memorial Hermann Northwest Hospital where an x-ray determined a distal radial fracture. He underwent surgery on 2/4/04 consisting of a closed reduction and percutaneous pinning of the left distal radial fracture and application of external fixator. The claimant underwent a second surgery on 3/11/04 to his left hand including manipulation under anesthesia. The claimant began active and passive modalities. The claimant was seen by R. S. Arora, M.D. for a designated doctor exam on 7/8/04, who reported the claimant was not at MMI but would be so in approximately 2 months. Active and passive modalities continued. According to a subsequent medical report by Jack T. Barnett, D.C. dated 9/21/04, the claimant underwent a second MRI on 8/2/04 that revealed McCauley's type fracture, significant effusion in the distal radial ulnar joint, with partial tear of the triangular fibrocartilage complex and partial tears of the scaphoid, lunate and triquetral ligaments were suspected. The documentation continues beyond the date of services requested for review.

Requested Service(s)

97110 – therapeutic exercises, 97035 – ultrasound, 97124 – massage, 98943 – chiropractic manipulation, 99211, 99214 - office visits, G0283 - electrical stimulation, E1399 – durable medical equipment (DME), 99070 – supplies, and A4556 – electrodes for dates of service 5/21/04 to 10/1/04

Decision

I disagree with the carrier that the services in dispute provided from 5/21/04 through 7/7/04 were medically necessary including 97110 (maximum of 4 units), 97035, 97124, 99211, and G0283. I agree with the carrier that the remainder of the services in question were not medically necessary.

Rationale/Basis for Decision

According to the supplied documentation, the claimant sustained an injury to his left wrist and forearm on ____. The claimant underwent surgery to correct the fracture and install hardware, and later to remove the hardware on 3/11/04. The claimant began passive and active therapy on 4/1/04. The claimant appeared to improve with therapy, therefore supporting the medical necessity of the treatment. After careful review of the supplied objective documentation, 5-6 units of 97110 (therapeutic exercise) is not seen as reasonable or medically necessary. The claimant was able to perform an hour and a half of active therapy which could be performed on a home based protocol without the need of doctor supervision. The claimant was seen by a designated doctor on 7/8/04 which revealed the claimant was not at MMI and was making progress with physical therapy. It would appear at that time, at approximately 4 months since the removal of his hardware, that the claimant could begin a home based exercise program to continue to benefit his symptoms without doctor supervision. The documentation supplied does not support the use of 99214 (evaluation code), extremity mobilization is also not seen as reasonable or medically necessary to treat a healing fracture. All of the therapies provided beyond the designated doctor report appear redundant and could be performed in a home based setting.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 23rd day of August 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder