



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

<b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address:	MDR Tracking No.: M5-05-2511-01
<b>SOUTHEAST HEALTH SERVICES INC</b> <b>PO BOX 170336</b> <b>DALLAS TX 75217</b>	Claim No.:
	Injured Worker's Name:
Respondent's Name and Address:	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:
<b>AMERICA FIRST LLOYDS INSURANCE</b> <b>C/O HARRIS &amp; HARRIS Box 42</b>	

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

DWC-60 package, EOBs, CMS-1500s. Position Summary: None submitted

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

DWC-60 response. Position Summary: None submitted

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
5-22-04 to 12-7-04	97799 Reimbursement determined by carrier.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	99211, \$27.86 x 9 days = \$250.74		
	99214, \$106.36		
	97140-59, \$34.13 x 5 days = \$170.65		
	97110 \$144.00 x 6 days = \$864.00		
	\$108.00 x 1 day = \$972.00		
	97750-FC, \$333.45		
	98940, \$33.61 x 11 days = \$369.71		
97012 (1st 10 applications), \$19.21 x 10 days = \$192.10			
97032 (1st 10 applications), \$20.20 x 10 days = \$202.00			
<b>Total Due</b>			\$3,461.01 plus DOP code
	93799, – Even though IRO determined this to be medically necessary, this service is included with an FCE per Rule 134.202; therefore, no additional reimbursement recommended.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$0.00
5-22-04 to 12-7-04	97016, 98943, 97012 (after 10 applications), 97032 (after 10 applications)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00

#### 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 **prevailed** on the majority of the disputed medical necessity issues.

Per Rule 134.202(c)(6) for products and services for which CMS or DWC does not establish relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published DWC medical dispute decisions, and values assigned for services involving similar work and resource commitments. Therefore, the carrier shall assign the reimbursement value for code 97799.

Based on review of the disputed issues within the request, Medical Review 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 6-21-05 Medical Review 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.

99080-73 billed for dates of service 6-29-04, 8-12-04, 9-7-04, 10-28-04, 11-23-04 was denied as unnecessary medical per peer review. This is a required report and not subject to an IRO review. This report is governed by rule 129.5. Therefore, recommend reimbursement of \$15.00 x 5 days = \$75.00. The carrier will be billed for inappropriate denial and a C&P referral will be made.

99080-73 billed for dates of service 7-19-04 and 7-28-04 was denied as unnecessary medical per peer review. This is a required report and not subject to an IRO review. This report is governed by rule 129.5. No examination was conducted on these dates of service. Requestor did not meet the requirements of rule 129.5. No reimbursement recommended.

Code 97010 billed for date of service 7-12-04 cannot be reviewed. Per the 2002 Medical Fee Guideline, this is a bundled code and considered an integral part of a therapeutic procedure. Regardless of whether it is billed alone or in conjunction with another therapy code, additional payment will not be made. Payment is included in the allowance for another therapy service/procedure performed. No review and no payment recommended.

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

28 Texas Administrative Code Sec. 133.308, 133.307, 134.202, 129.5

**PART VII: DIVISION DECISION AND ORDER**

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 entitled to additional reimbursement in the amount of \$3,461.01 plus DOP. In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee (\$460.00). 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.

Ordered by:

Medical Dispute Officer

11-7-05

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.**

# 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

IRO #: 5251

Amended September 6, 2005

August 4, 2005

TWCC Medical Dispute Resolution

Fax: (512) 804-4868

Patient: \_\_\_\_\_

TWCC #: \_\_\_\_\_

MDR Tracking #: M5-05-2511-01

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. 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: Narrative report from Bryan Weddle DC, Lumbar MRI, lower extremity NCV/EMG, report from Charles Willis MD, peer review from R.A. Buczek D.O., D.C., DD exam from George Shropulos MD, report from Francisco Battle MD, treatment notes from Bryan Weddle DC, psychological evaluation from Karen Cuttill MA, LPC-intern.

### CLINICAL HISTORY

This patient is employed by \_\_\_\_\_ where he has been employed for some time and is working as a forklift driver. On \_\_\_\_, while operating the forklift, he was picking up a coil. It became stuck so he stepped off the forklift and was attempting to push the coil onto the forklift when the two by four foot coil fell, landing on both thighs and scraping both legs. The impact of the coil caused him to be thrown backwards into another stack of two by four foot coils where he hit and injured his low back.

## **DISPUTED SERVICE(S)**

Under dispute is the retrospective medical necessity of Unlisted physical medicine/rehab 97799, office visits 99211 and 99214, manual therapy technique 97140-59, mechanical traction 97012, vasopneumatic device 97016, 98940 and 98943, electrical stimulation (manual) 97032, therapeutic exercise 97110, FCE 97750-FC, and unlisted cardiovascular service and procedure 93799 for dates of service 5-22-04 to 12-07-04.

## **DETERMINATION/DECISION**

The Reviewer partially agrees with the determination of the insurance carrier in this case. The Reviewer agrees with the insurance carrier on the following: vasopneumatic device 97016, mechanical traction 97012 after 10 applications, electrical stimulation (manual) 97032 after 10 applications, chiropractic manipulative therapy 98943 (extremity); the Reviewer disagrees with insurance carrier on the following: physical medicine/rehab 97799, office visits 99211 and 99214, manual therapy technique 97140-59, unlisted cardiovascular service and procedure 93799, therapeutic exercise 97110, FCE 97750-FC, mechanical traction 97012 first 10 applications, electrical stimulation (manual) 97032 first 10 applications, chiropractic manipulative therapy 98940 (one area).

## **RATIONALE/BASIS FOR THE DECISION**

The date of injury of this case is \_\_\_\_\_. The denial of dates of service began May 22, 2004 and Explanation of Reviews reveals that the Corvel medical director deemed these services medically unnecessary. The only services that are medically unnecessary are the vasopneumatic device, which is redundant and have similar benefits as the electric stimulation and manual therapy techniques. Also, the mechanical traction and the electrical stimulation are unnecessary after 10 sessions, which would allow the patient to move into the active phase of treatment. The reviewer agrees with the peer review by R.A. Buczek DO, DC, "...I do not hold out much hope for substantial pain relief with either the Matrix, or DRX 9000 treatments. Therefore, I would limit both of these treatment options to 10 sessions only, unless substantial objective benefit can be ascertained." The CPT code 98943 is unreasonable due to the low back being the only compensable body part, and the 98943 code implies an extremity adjustment. As far as the other services that were provided within the disputed treatment dates, they are reasonable and necessary and fit within the *Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters*. It is very important to utilize the active treatment in patient care as soon as possible to prevent deleterious onset of physician dependence, somatization, chronicity, illness behavior, and de-conditioning all of which are adverse and lead to over utilization.

### **Screening Criteria**

1. Specific:

- \* Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters
- \* Peer Review, R.A. Buczek DO, DC

2. 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 "Roger Glenn Brown", with a long horizontal flourish extending to the right.

Dr. Roger Glenn Brown

**President & Chief Resolutions Officer**