



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.: M5-05-2960-01
<b>Fort Worth Injury</b> <b>101 W Allen Avenue</b> <b>Fort Worth TX 76110</b>	Claim No.:
	Injured Worker's Name:
Respondent's Name and Address:  <b>Box 03</b>	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

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

DWC-60 package. Position Summary: Documentation supports medical necessity.

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

Response to DWC-60 package. Position Summary: Excessive PT per utilization review standards.

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

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
7-12-04 to 8-27-04	97112-59 18 units x \$35.66 = \$641.88	☒ Yes ☐ No	\$2,549.17
	97116-59 17 units x \$30.59 = \$520.03		
	97110-59 54 units x \$25.69 = \$1,387.26	☒ Yes ☐ No	\$3718.52
	97140-59 34 units x \$32.90 = \$1,118.60		
	97530-59 72 units x \$36.11 = \$2,599.92		
	99215-25 1 day x \$147.68	☒ Yes ☐ No	\$147.68
	<b>TOTAL</b>		<b>\$6,415.37</b>

#### 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 disputed medical necessity issues.

The disputed dates of service 7-2-04 through 7-9-04 are untimely and ineligible for review per DWC Rule 133.308 (e)(1).

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 8-1-05, Medical Review submitted a Notice to the 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 E0745-RR billed on 7-30-04 and 8-27-04 was denied as 'A, 240 – preauthorization not obtained'. Per Rule 134.600 (h) (11) all DME in excess of \$500.00 per item (either purchase or expected cumulative rental) and all TENS units require preauthorization. The requestor did not submit a preauthorization approval letter. Therefore, no reimbursement recommended.

Code E1399-NU billed on 7-14-04 (two sets of TENS pads), 7-26-04 (one set), 8-06-04 (two sets), 8-19-04 (two sets), and 8-27-04 (one set) was denied as 'A, 240 – preauthorization not obtained'. Preauthorization is not required for TENS supplies. Per the 2002 Medical Fee Guideline, TENS supplies have an alternative code. Also, modifier –NU is invalid when used with E1399. Therefore, no reimbursement recommended.

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

28 Texas Administrative Code Sec. 133.308, 134.202, 134.600

**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 \$6,415.37. In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of \$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.

Findings & Decision by:

Medical Dispute Officer

1-13-06

Authorized Signature

Typed Name

Date

Ordered by:

Manager

Medical Necessity Team

1-13-06

Authorized Signature

Typed Name

Date

**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.**



# PROFESSIONAL ASSOCIATES

## NOTICE OF INDEPENDENT REVIEW

**NAME OF PATIENT:** \_\_\_\_\_  
**IRO CASE NUMBER:** M5-05-2960-01  
**NAME OF REQUESTOR:** Ft. Worth Injury  
**NAME OF PROVIDER:** George Wilson, D.C.  
**REVIEWED BY:** Licensed by the Texas State Board of Chiropractic Examiners  
**IRO CERTIFICATION NO:** IRO 5288  
**DATE OF REPORT:** 09/08/05 (REVISED 01/09/06)

Dear Ft. Worth Injury:

Professional Associates has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO) (#IRO5288). Texas Insurance Code Article 21.58C, effective September 1, 1997, allows a patient, in the event of a life-threatening condition or after having completed the utilization review agent's internal process, to appeal an adverse determination by requesting an independent review by an IRO.

In accordance with the requirement for TDI-Division of Workers' Compensation (DWC) to randomly assign cases to IROs, DWC has assigned your case to Professional Associates for an independent review. The reviewing physician selected has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, the reviewing physician reviewed 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. determination, and any documentation and written information submitted in support of the appeal.

This case was reviewed by a physician reviewer who is Licensed in the area of Chiropractics and is currently listed on the DWC Approved Doctor List.

I am the Secretary and General Counsel of Professional Associates and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him the provider, the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the Independent Review Organization.

### REVIEWER REPORT

#### Information Provided for Review:

An evaluation dated 06/03/04 from G. Kris Wilson, D.C.

A letter from Dr. Wilson dated 06/03/04 noting the patient had been provided with an EMS-5000 unit starting on 06/03/04  
Treatment with Dr. Wilson dated 06/07/04, 06/08/04, 06/09/04, 06/10/04, 06/11/04, 06/14/04, 06/15/04, 06/16/04, 06/17/04, 06/18/04, 06/21/04, 06/23/04, 06/25/04, 06/28/04, 06/30/04, 07/02/04, 07/06/04, 07/07/04, 07/09/04, 07/12/04, 07/14/04, 07/16/04, 07/19/04, 07/21/04, 07/23/04, 07/26/04, 07/28/04, 07/30/04, 08/02/04, 08/04/04, 08/06/04, 08/09/04, 08/11/04, 08/13/04, 08/18/04, 08/19/04, 08/20/04, 08/23/04, 08/25/04, and 08/27/04

An evaluation by Dr. Patrick E. Davis (credentials were not provided) on 07/02/04

An MRI of the lumbar spine dated 07/21/04 and interpreted by Mark Meiches, M.D.

Another evaluation by Dr. Davis dated 07/30/04

A follow-up evaluation dated 08/27/04 from Dr. Davis  
An impairment rating report from Dr. Wilson dated 08/31/04  
A TWCC-69 dated 08/31/04 from Dr. Wilson

**Clinical History Summarized:**

The patient was initially evaluated by Dr. Wilson on 06/03/04. It was noted the patient qualified for an off work status effective 06/03/04. The patient was prescribed an EMS unit on a rental basis. The patient attended therapy with Dr. Wilson from 06/07/04 through 08/27/04 and received myofascial release, neuromuscular reeducation, gait training, therapeutic procedures, deep heat analgesic application, kinetic procedures, and manipulative procedures. On 07/02/04, Dr. Davis evaluated the patient and a continuation of the prescribed active procedures three times a week for four weeks was recommended. An MRI of the lumbar spine dated 07/21/04 revealed multilevel lumbar facet arthropathy without evidence of spinal stenosis. Dr. Davis recommended additional treatment sessions on 07/30/04. On 08/27/04, Dr. Davis noted the patient had completed approximately 12 weeks of conservative treatment and was formally being discontinued from physical Therapy. She was to return to the office once a week. Dr. Davis performed an impairment rating on 08/31/04 and placed the patient at clinical Maximum Medical Improvement (MMI) on 08/31/04 and assigned the patient 5% whole person impairment rating.

**Disputed Services:**

Manual therapy techniques, neuromuscular reeducation, aquatic therapy, therapeutic exercises, office visits, and therapeutic activities from 07/12/04 through 08/27/04

**Decision:**

I agree with the requestor. The manual therapy techniques, neuromuscular reeducation, aquatic therapy, therapeutic exercises, office visits, and therapeutic activities from 07/12/04 through 08/27/04 were reasonable and necessary.

**Rationale/Basis for Decision:**

The treatment provided to the patient satisfied the qualifications of Section 408.021 of the Texas Labor Code, which only substantiated the need for care, which (1) cures or relieves the effects naturally resulting from the compensable injury, (2) promotes recovery, or (3) enhances the ability of the employee to return to or retain employment. Based upon review of the provided documentation, the patient's condition appeared to progress with a reasonable pace under the treatment plan provided by Dr. Wilson. Therefore, based upon the supplied documentation, the above mentioned services provided by Dr. Wilson between 07/12/04 and 08/27/04 did satisfy the qualifications of Section 408.021 and were, therefore, reasonable and necessary, and causally related to the original injury.

The rationale for the opinions stated in this report are based on clinical experience and standards of care in the area as well as broadly accepted literature which includes numerous textbooks, professional journals, nationally recognized treatment guidelines and peer consensus.

This review was conducted on the basis of medical and administrative records provided with the assumption that the material is true and correct.

This decision by the reviewing physician consulting for Professional Associates is deemed to be a Division decision and order.

**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. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). 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.

If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision. A request for a hearing should be faxed to 512-804-4011 or sent to:

Chief Clerk of Proceedings/Appeals Clerk  
TDI-Division of Workers' Compensation  
P. O. Box 17787  
Austin, TX 78744

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization's decision was sent to DWC via facsimile or U.S. Postal Service on 01/09/06 from the office of Professional Associates.

Sincerely,

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Lisa Christian  
Secretary/General Counsel