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 Rafael Loya, D. C. 2973 Bingle Rd. Houston, TX 77055	MDR Tracking No.: M5-05-3053-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Liberty Mutual Fire Insurance, Box 28	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS – MEDICAL NECESSITY ITEMS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	**To**		
3-18-04	**6-21-04**	**CPT codes 99211, 99212, 97110, 97530**	☒ **Yes** ☐ **No**
3-18-04	**6-21-04**	**CPT code 97112**	☐ **Yes** ☒ **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 majority of the disputed medical necessity issues. The amount due the requestor for the medical necessity issues is $2,508.67.

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 8-2-05 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.

All services from 1-12-04 through 6-21-04 were denied by the carrier as "R – the service is for a condition which is not related to the covered work related injury." A benefit review conference on January 6, 2005 determined that the injury of extends to and includes right tarsal tunnel syndrome. Recommend reimbursement of these services as follows:

CPT code 99211 – $27.04 X 7 DOS = $189.28
CPT code 99212 – $48.03 X 1 DOS = $48.03
CPT code 97035 – $15.78 X 3 DOS = $47.34
CPT code 97124 – $28.09 X 3 DOS = $84.27
CPT code 97530 – $37.21 X 4 DOS = $148.84
CPT code 97032 – $20.04 X 3 DOS = $60.12
CPT code 97112 – $36.75 X 4 DOS = $147.00

Regarding CPT code 97110 from 1-12-04 through 6-21-04: Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Reimbursement not recommended.

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 $3,233.55, consistent with the applicable fee guidelines plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Findings and Decision by:

		8-31-05
Ordered by:		
		8-31-05
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 in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

Specialty Independent Review Organization, Inc.

August 25, 2005

TWCC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient:
TWCC #:
MDR Tracking #: M5-05-3053-01
IRO #: 5284

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

Specialty IRO has performed an independent review of the care rendered 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.

This case was reviewed by a licensed Chiropractor. The reviewer is on the TWCC ADL. The Specialty IRO health care professional 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 Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

According to the records received and reviewed, the injured employee ___ was injured in a work related accident on ___. Ms. ___ was working for when she was injured. The injured employee was delivering packages for when her pant leg got caught in the wheel of a dolly that she was using. Ms. ___ fell forward landing on her right knee and twisting her right ankle. It is also noted that the injured employee had a prior ankle injury in ___.

Numerous treatment notes, diagnostic tests, staffing notes, evaluations, and other documentation were reviewed for this file. Specific records identified include but are not limited to the following:

Medical Dispute Records
EOB's from the Insurance Carrier
TWCC Hearings Division Docket Order
North Houston Imaging Center MRI of the right knee
North Houston Imaging Center MRI of the right ankle
DD report by Dr. Simpson
North Houston Imaging Center MRI of the lumbar spine
Report from Dr. Gunther
Records from Shanti Pain & Wellness Clinic

Report from Dr. Awitan
Records from Cy-Fair Bone & Joint
FCE by Bingle Crossing Clinic
ESI reports from Dr. Shanti
DD report by Dr. Fraser
Records from Dr. Loya
MMI/IR from Dr. Loya on 8-19-2004
Electrodiagnostic report from Dr. Mendoza
Letter from Liberty Mutual
Report from Dr. Sato

DISPUTED SERVICES

The items in dispute are the retrospective medical necessity of office visits-99211/99212, therapeutic exercise-97110, therapeutic activities-97530 and neuromuscular re-education-97112 from 3/18/04 through 6/21/04.

DECISION

The reviewer disagrees with the previous adverse determination regarding the office visits 99211/99212, therapeutic exercises 97110, and therapeutic activities 97530.

The reviewer agrees with the previous adverse decision regarding neuromuscular re-education 97112.

BASIS FOR THE DECISION

The basis for the determination is based upon the Medical Disability Advisor, Evidenced Based Medical Guidelines, Medicare Payment Policies, and Occupational Medicine Practice Guidelines. Ms. ___ had a significant injury and injured multiple body areas to include the lumbar region, the knee and the ankle. She had multiple diagnoses, which would be a complicating condition to her recovery. Ms. ___ had positive electrodiagnostics confirming the nerve compromise in the foot. In addition, she had a previous injury and surgery to her ankle which although is not considered compensable to the work related injury, it must be considered as a complicating condition that would delay her recovery period. The MDA also states, "Individuals with tarsal tunnel syndrome may be partially or completely disabled for 6-12 months while the posterior tibial nerve regenerates and symptoms subside." In addition Ms. ___ attended two different Designated Doctors during the time period under review and both Designated Doctors stated that the patient was not at maximum medical improvement, the latest being on 6-29-2004. The documentation does not support nor adequately identify the use of neuromuscular re-education. Although the actual code may be appropriate to this case, there is inadequate documentation for the code.

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

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

Sincerely,

Wendy Perelli, CEO

CC: Specialty IRO Medical Director