



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:	MDR Tracking No.: M5-05-3064-01 - Corrected
NorthEast Rehab 791 S. Highway 78 Wylie, TX 75098	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Atlantic Mutual Insurance Company, Box 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included the TWCC 60 form, Explanations of Benefits and CMS 1500's. Position summary states, "The insurance carrier has denied all the claims twice due to a peer review performed on August 12, 2004. This represents an egregious abuse of the paper review process. The carrier has suppressed evidence and provided only what documentation might support denial of payment for services the patient is entitled to."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No position summary was received.

PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
8-12-04	CPT code 99213	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$49.58
8-18-04 – 12-1-04	Up to three units of CPT code 97110	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	3,225.69
8-18-04 – 12-30-04	CPT code 99213 (except on 8-12-04), more than 3 units of CPT code 97110, 97032, 97035, 97140, 97150	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	-0-

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 prevail on the majority of the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$3,275.27.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 134.202.

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 carrier must refund the amount of the IRO fee (\$460.00) to the requestor within 30 days of receipt of this order. The Division has determined that the requestor is entitled to reimbursement in the amount of \$3,275.27. 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 and Decision and Order by:

Authorized Signature

Typed Name

03-08-06

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.



Specialty Independent Review Organization, Inc.

September 29, 2005

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

Patient: _____
TWCC #: _____
MDR Tracking #: M5-05-3064-01
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

_____ was injured on _____ while working for _____. Apparently, she was carrying approximately 80 pounds of cable when she felt lower back pain. She measures approximately 5' 10 1/2" and weighs 258 pounds according to the records. She is being treated by Ryan Maguire, DC and Steven Bander, DO. She has had an MRI, which indicates bulging at L4/5, stenosis and mild foraminal narrowing at L5/S1 and facet hypertrophy at L3/4. She has underwent pharmacological, ESI and was recommended for surgery by several physicians. The lumbar myelogram indicates multiple problems from L4 through S1. Ms. Lugrand had a lumbar laminectomy at L4/5 and L5/S1 on May 24, 2004 with Benjamin Cunningham, MD. She was released to rehab on 8/17/04 by Dr. Cunningham. She performed well on her 10/7/04 FCE. She was placed in a work-conditioning program in January 2005. She was placed at MMI on 01/25/05 by Becky Personett, MD.

RECORDS REVIEWED

Records were received from the requestor/treating doctor and the respondent. Records reviewed from the requestor/treating doctor include the following: 7/20/05 letter by Ryan Maguire, DC, 6/1/05 report by Donald Mauldin, MD, 3/8/05 DD report by Becky Personett, MD, 2/23/04 IR report by Kirtland Speaks, DC, 12/3/04 RME report by Mark Doyne, MD, 02/04/04 to 8/17/04 notes by B. Cunningham, MD, 10/12/04 script for WH by Dr. Steven Bander, DO, intermediate FCE of 10/7/04, 8/17/04 post op script by Dr. Cunningham, response to peer review report, 8/12/04 report by Michael Albrecht, MD, 3/9/04 lumbar myelogram report, initial FCE of 12/16/03, 10/15/03 through 12/3/03 reports by Steven Remer, MD, 11/06/03 through 11/20/03 ESI operative reports, neurodiagnostic report of 9/18/03, 9/8/03 lumbar MRI and 8/20/03 initial exam notes from NE rehab.

Records from the respondent include some of the above in addition to the following: 7/29/05 RME report by Mark Doyne, MD, 08/24/04 through 11/10/04 reports by S Bander, DO, SOAP notes from NE Rehab from 8/14/04 through 12/21/04, lumbar protocol

sheet from 8/18 through 12/21/04, 11/17/04 report by B. Cunningham, MD, MJM confidential report of 12/30 through 12/31/04, 12/2/04 FCE and 6/24/04 and 8/12/04 notes by Kay Drose, RN.

DISPUTED SERVICES

Disputed services include the following codes: 99213, 97110, 97140, 97035, 97032 and 97150 from 8/12/04 through 12/30/04.

DECISION

The reviewer agrees with the previous adverse determination regarding the following codes on the following dates: 97032 (all dates under review), 97035 (9/22/04), 97140 (all dates under review) and 97150 (all dates under review).

The reviewer disagrees with the previous adverse determination regarding the following codes on the following dates: 97110 (up to three units on each DOS from 8/18/04 through 12/01/04) and 99213 (8/12/04).

BASIS FOR THE DECISION

The reviewer indicates that the surgeon released the patient to post-surgical rehabilitation program on 8/17/04. She began rehabilitation on 8/18/04. According to McFarland C, Burkhart D Rehabilitation Protocols for Surgical and Nonsurgical Procedures-Lumbar Spine 1999, the lumbar decompression patient can usually begin a rehab program within six to eight weeks post surgery. Unfortunately this patient had complications, which led to a long delay of post-surgical treatment. The authors indicate that the program should consist of approximately eight weeks of rehabilitation. The FCE of 10/7/04 is difficult to compare to the pre-surgical status of the patient as they compare the results to a 12/16/03 FCE. However nearly all results have improved since the earlier examination. The FCE on 12/2/04 by a Chris Moody (unknown if this is a professional or a layperson) and signed by the medical director (name cannot be read) indicates she is not providing good effort. As per TLC 408.021, the patient improved functionally through 12/1/04; therefore, the rehabilitative treatment is considered medically necessary.

The reviewer indicates that the office visit (99213) is within the normal protocol for the evaluation of treatment on the date, which is approved. Code 97032 is for an attended therapy and the notes do not indicate that this was performed, nor is it medically necessary as the patient did not require an attended therapy at this stage of treatment.

Three units of 97110 are approved as per the accepted Medicare Guidelines, which limit the number of units of rehab therapy that can be performed on a daily basis to 45 minutes without the documentation for the medical necessity of more treatment. The code 97140 was not documented in the daily SOAP notes. The closest thing that was in the daily notes was the usage of a flexion/distraction table; however, it was not on each date, which was submitted, for review and it was not provided with a time component.

Therapeutic group activities and ultrasound were not documented in the SOAP notes that were provided. Therefore, they were found to be not medically necessary.

REFERENCES

McFarland C, Burkhart D Rehabilitation Protocols for Surgical and Nonsurgical Procedures-Lumbar Spine 1999

ACOEM Guidelines

Reed, P The Medical Disability Advisor, 2005

NASS Phase III Clinical Guidelines.

Physiotherapy and Rehabilitation Guidelines by the Council of Chiropractic Physiological Therapeutics and Rehabilitation 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
