



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.: M5-05-3190-01
Rehab Affiliates 9150 Huebner Rd. Ste 340 San Antonio, TX 78240	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Insurance Company, Box 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included TWCC 60 form, Explanations of Benefits and CMS 1500's.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The requestor sent the TWCC 60, Part VI and the Explanation of Benefits. The carrier states that they paid \$1,966.87 on a \$3,840.00 bill.

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)
11-8-04, 11-11-04, 11-15-04	CPT code 97110	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$103.38

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 the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$103.38.

Based on review of the disputed issues within the request, the 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 Medical Dispute Resolution.

On 8-15-05 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 97002 on 11-18-04 was denied by the carrier as "435 – the value of this procedure is included in the value of the comprehensive procedure." Per the 2002 MFG, CPT code 97002 is considered by Medicare to be a component procedure of CPT code 97110 which was billed on this date of service. Recommend no reimbursement.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308

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 parties are instructed to review the IRO decision and take appropriate action. For any services that may have been found to be medically necessary, the insurance carrier is instructed to process those services through their bill review and payment processes, including issuing any additional amounts due consistent with the established fee guidelines. The requestor is not entitled to a refund of the IRO fee. 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 \$103.38. 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:

_____	Donna Auby	9-15-05
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.



Specialty Independent Review Organization, Inc.

September 1, 2005

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

Patient:
TWCC#:
MDR Tracking #: M5-05-3190-01
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 Doctor of Osteopathy with a specialty in Orthopedics. 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

This 24 year old male injured his low back on _____. The patient works as a heavy equipment operator and on the date of injury he was repairing a water pipe and jerked forward, twisting and falling to the ground. The patient developed low back pain and was seen in the Emergency Room for the initial care.

The physical examination reveals lumbar spasm, no motor or sensory deficits, negative straight leg raise. The MRI of 10/20/2004 reveals a Grade I spondylolisthesis at L5-S1 and moderately severe bilateral foraminal stenosis at L5-S1. The patient received ESIs on 12/21/2004 and 01/18/2005. The physical therapy from 11/08/2004 through 02/25/2005 consisted of 61 therapeutic exercise and 4 gait training sessions.

RECORDS REVIEWED

Texas Mutual EOBs – No Dates.
Texas Mutual Letter – 08/23/2005.
Radiology Associates, MRI – 10/20/2004.
J Borkowski MD, Reports – 11/01/2004 through 01/06/2005.
T Edwards MD, Report – 12/08/2004.
Corpus Christi Surgery Center, OP Notes – 12/21/2004, 01/18/2005.

Records from Carrier:

J Borkowski MD, Reports – 11/01/2004 through 03/02/2005.

Calallen – PT Reports – 11/03/2004 through 02/25/2005.

D Young AT, Report – 08/22/2005

DISPUTED SERVICES

Disputed services include the following: 97110 therapeutic exercises and 97115 gait training from 11/8/04 through 2/25/05.

DECISION

The reviewer disagrees with the previous adverse determination regarding code 97110 on the following dates: 11/8/04, 11/11/04 and 11/15/04.

The reviewer agrees with the previous adverse determination regarding all remaining codes under review.

BASIS FOR THE DECISION

This 24 year old male injured his low back on _____. The injury was an aggravation of the Grade I spondylolisthesis of L5-S1. The patient had no evidence of gait problems, there was no surgery, and there was no need for any gait training. Gait training 97116 was done on 11/08, 11/09, 11/11, and 11/15/2004. These are all non-certified.

The patient received 61 therapeutic exercise sessions (97110) from 11/08/2004 through 02/25/2005. The patient should receive physical therapy for 3-6 visits following the injury so that he can be taught home exercises. The sessions of 11/08, 11/11, and 11/15/2004 are CERTIFIED. The remaining 58 sessions are not necessary and are non-certified.

REFERENCES

Brotzman & Wilk: CLINICAL ORTHOPEDIC REHABILITATION, 2nd Edition.

D Stude: SPINAL 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