



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: Southeast Health Services P. O. Box 453062 Garland, TX 75045	MDR Tracking No.: M5-05-3209-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Hartford Ins Company of the Midwest, Box 27	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included DWC 60 form, Medical Documentation, Explanations of Benefits and CMS 1500's. Position summary states, "Please see attached Letter of Medical Necessity."

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)
10-11-04 – 12-22-04	3 units of CPT code 97110 for each date of service, CPT code 98940, CPT code 97032, CPT code 99214, CPT code 97016, CPT code 97530	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2,945.88.
10-11-04 – 2-23-05	CPT code 97032 and CPT code 97113	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
12-28-04 – 2-23-05	CPT code 97110, CPT code 98940, CPT code 97032, CPT code 97016, CPT code 97530	<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 disputed medical necessity issues as follows:

3 units of CPT code 97110 - \$1,109.70 (\$110.97 X 10 DOS)

CPT code 98940 – \$604.98 (\$33.61 X 18 DOS)

CPT code 97016 - \$110.40 (\$18.40 X 6 DOS)

CPT code 99214 - \$212.72 (\$106.36 x 2 DOS)

CPT code 97140 - \$682.60 (\$34.13 X 20 DOS)

2 units of CPT code 97530 - \$225.48 (\$75.16 X 3 DOS)

The amount due the requestor for the items denied for medical necessity is \$2,945.88.

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 9-6-05 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 98940 on 1-19-05 and CPT code 99211 on 2-14-05 were withdrawn by the requestor and will not be a part of this review.

CPT code 97140-59 on 10-11-04 and 2-8-05 was denied as "F - This procedure is considered integral to the primary procedure billed." CPT code 97140 is considered by Medicare to be a component procedure of CPT code 98940. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be considered justifiable if a modifier is used appropriately. The requestor correctly used a modifier to denote a distinct procedure. Recommend reimbursement of \$68.26 (\$34.13 x 2 DOS).

The carrier denied CPT Code 99080-73 on 11-12-04 and 11-19-04 with a "V" for unnecessary medical treatment based on a peer review; however, the DWC-73 is a required report per Rule 129.5 and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter; Recommend reimbursement of \$30.00 (\$15.00 X 2 DOS).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 129.5 and 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 carrier must refund the amount of the IRO fee (\$460.00) within to the requestor within 30 days of receipt of this order. The requestor is entitled to reimbursement in the amount of \$3,044.14. 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

12-6-05

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.

October 5, 2005

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

Patient:
TWCC #:
MDR Tracking #: M5-05-3209-01
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 in a work related accident on ____. The patient was at work and lifting a mail crate she injured her low back and experienced pain, numbness and tingling radiating into her right hip and right leg. ___ was working for First Horizon National Corporation when she was injured. The patient subsequently initiated care with Dr. Weddle.

Numerous treatment notes, diagnostic tests, evaluations, and other documentation were reviewed. Records included but were not limited to the following:

- Medical Dispute Resolution paperwork
- Numerous EOB's
- Letter of Medical Necessity from Dr. Weddle
- Treatment Records
- Dispute of MMI by Dr. Weddle
- Reports from Dr. Willis
- Report from Digestive Health Associates
- Letter from Law Offices of Marye & Associates
- Report from Dr. Battle
- DD Report from Dr. Arora giving MMI 5% on 12-22-2004
- Neurodiagnostic report from Neuroscience Center
- Lumbar MRI from Up & Open Imaging
- Report from Radiology Consultants of North Texas
- Report from Liberty Healthcare

DISPUTED SERVICES

The items in dispute are the retrospective medical necessity of 98940/98943-chiropractic manipulation, 97110-therapeutic exercises, 97032-electrical stimulation, 97016-vasopneumatic devices, 97530-therapeutic activities, 97140-manual therapy technique, 97113-aquatic therapy and 99211/99214-office visits from 10-11-2004 through 2-23-2005.

DECISION

The reviewer agrees with the previous adverse decision regarding 97032 for all dates of service under review.

The reviewer agrees with the previous adverse decision regarding 97113 for all dates of service under review.

The reviewer disagrees with the previous adverse decision regarding the remaining services from 10-11-2004 through 12-22-2004 with the exception that the reviewer agrees with only up to 3 units of 97110 for each date of service under review.

The reviewer agrees with the previous adverse decision regarding all services after 12-22-2004.

BASIS FOR THE DECISION

The basis for the determination is based upon the Medical Disability Advisor, the Official Disability Guidelines, and Evidence Based Medicine Guidelines. The Medicare guidelines and payment policies were also utilized in the decision making process of this review. Medicare payment policies state, "for all PM&R modalities and therapeutic procedures on a given day, it is usually not medically necessary to have more than one treatment session per discipline. Depending on the severity of the patient's condition, the usual treatment session provided in the home or office setting is 30 to 45 minutes. The medical necessity of services for an unusual length of time must be documented." The treating doctor does not provide adequate documentation as to why the patient would need more than 45 minutes of combined rehabilitation per day.

Due to the fact that the patient had the presence of a neurological insult and documented disc injuries, the reviewer does grant the full 45 minutes of rehabilitation for each date of service and also would allow one unit of manual therapy in addition to the 45 minutes of rehabilitation due to the patients documented injuries. The MDA gives approximately 3 months for the duration of length of disability for this type of injury as identified below:

Lumbar Sprain/Strain

Job Classification	Minimum	Optimum	Maximum
Sedentary	1	3	7
Light	1	7	14
Medium	3	14	28
Heavy	7	21	42
Very Heavy	7	28	56

Job Classification	Minimum	Optimum	Maximum
Sedentary	1	7	14
Light	1	14	21
Medium	1	21	42
Heavy	1	56	91
Very Heavy	1	91	168

In regards to 97032, the documentation does not support the use of attended electrical stimulation compared to non-attended electrical stimulation. There is no clinically documented necessity for the electrical stimulation to need constant attendance. There is also no specific documentation showing the need for aquatic therapy as opposed to land based therapy especially considering the fact that the patient was already participating in land based therapy prior to the aquatic therapy being initiated. It should also be noted that the patient was placed at MMI with a 5% impairment rating by a Designated Doctor Dr. Arora on 12-22-2004.

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

Your Right To Appeal

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.

Sincerely,

Wendy Perelli, CEO

I hereby certify, in accordance with TDI-DWC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the DWC via facsimile, U.S. Postal Service or both on this 5th day of October 2005

Signature of Specialty IRO Representative:

Name of Specialty IRO Representative: Wendy Perelli