



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> <input checked="" type="checkbox"/> Health Care Provider <input type="checkbox"/> Injured Employee <input type="checkbox"/> Insurance Carrier	
Requestor's Name and Address: Pain & Recovery Clinic C/o Bose Consulting, LLC P O BOX 550496 Houston, Texas 77255	MDR Tracking No.:                      M5-05-3233-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Utica Mutual Insurance Company Box 01	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

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

DOCUMENTATION SUBMITTED: TWCC-60, explanations of benefits, CMS 1500's and medical documentation

POSITION SUMMARY: Necessary treatment (per the table of disputed services)

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

DOCUMENTATION SUBMITTED: Response to TWCC-60 and screen prints of payment information

POSITION SUMMARY: "The medical necessity of services for an unusual length of time must be documented". The provider did not document the necessity for additional time.

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

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
08-16-04 to 11-16-04	97002 (\$50.00 X 1 DOS = \$50.00) 97032 (1 unit @ \$20.04 X 30 DOS = \$601.20) 97140 (1 unit @ \$33.91 X 30 DOS = \$1,017.30)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,668.50
08-16-04, 08-20-04, 08-31-04, 09-07-04, 09-17-04, 09-24-04, 10-04-04 and 10-18-04	99212 (\$48.03 X 8 DOS = \$384.24)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$384.24
08-16-04 to 11-16-04	99191, 99213, 99212 (except DOS listed above), 99214, 97110, 97112 and E1399	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

#### 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 disputed medical necessity issues.

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 Medical Dispute Resolution.

On 09-06-05, 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.

Date of service 07-27-04 per Rule 133.308(e)(1) was not timely filed and will not be a part of the review.

The requestor submitted an updated table of disputed services on 09-27-05 which included payment information. The review is per the updated table.

CPT code 99080-73 date of service 08-30-04 denied with denial code "V" (unnecessary treatment with peer review). Per Rule 129.5 the TWCC-73 is a required report and not subject to an IRO review. Reimbursement is recommended in the amount of **\$15.00**. A Compliance and Practices referral will be made due to the carrier being in violation of Rule 129.5.

CPT codes 97140, 97110 and 97112 date of service 09-13-04 denied with denial code "N" (not appropriately documented). Per Rule 133.307(g)(3)(A-F) the requestor submitted documentation, however, the documentation does not support the services in dispute. No reimbursement recommended.

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

28 Texas Administrative Code Sec. 133.308, Rules 129.5, 133.307(g)(3)(A-F) and 133.308(e)(1)

**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 \$2,067.74. 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. The Division finds that the requestor was not the prevailing party and is not entitled to a refund of the IRO fee.

Findings and Decision and Order by:

10-03-05

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
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.**



7600 Chevy Chase, Suite 400  
Austin, Texas 78752  
Phone: (512) 371-8100  
Fax: (800) 580-3123

## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** September 19, 2005

**To The Attention Of:** DWC  
7551 Metro Center Drive, Suite 100, MS-48  
Austin, TX 78744-16091

**RE: Injured Worker:**  
**MDR Tracking #:** M5-05-3233-01  
**IRO Certificate #:** IRO 5263

Forté has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Division of Workers' Compensation (DWC) at the Texas Department of Insurance has assigned the above referenced case to Forté for independent review in accordance with DWC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, 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 was reviewed.

The independent review was performed by a Chiropractic reviewer who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

### **Submitted by Requester:**

- Statement position letter
- Documentation from referral doctors
- Employee doctor notes
- Physical therapy notes
- FCE notes
- Treating doctor narrative reports
- Bone scan report
- Daily progress notes

### **Submitted by Respondent:**

- Table of disputed services
- Peer review
- Designated doctor report dated 4/4/05
- Statement letter

## **Clinical History**

According to the supplied documentation, the claimant sustained an injury on \_\_\_ when he was carrying a large platform that fell and landed on the distal aspect of his right foot. The claimant was initially seen by a company doctor who prescribed medications and performed some physical therapy. The claimant continued to have pain and changed treating physicians to William H. Hicks, D.C. and began treatment on 5/25/04. Dr. Hicks reported the claimant had a crush injury to the right lower extremity and to rule out nonunion fracture. Dr. Hicks then prescribed physical rehabilitation 3 times per week for 4 weeks including therapeutic exercises and manual therapy techniques. On 6/3/04, the claimant was seen by Anthony J. Lamarra, D.P.M. for an evaluation. Dr. Lamarra performed x-rays and determined the claimant had a fracture intraarticular at the base of the 4<sup>th</sup> digit. Dr. Lamarra diagnosed the claimant with a crush injury, neuritis, neuromas, fractured digits, foot sprain and causalgia. Dr. Lamarra prescribed orthotics, medications and reported the claimant should continue physical therapy. Passive and active modalities continued. The documentation supplied continued beyond the dates of service in question and was not reviewed.

## **Requested Service(s)**

99191 – assembly and operation of pump with oxygenator, 99212, 99214 – office visit, 97032 – electrical stimulation, 97140 – manual therapy technique, 97110 – therapeutic exercises, 97112 – neuromuscular re-education, E1399 – durable medical equipment, 97002 – physical therapy re-evaluation for dates of service 8/16/04 to 11/16/04

## **Decision**

I disagree with the carrier and find that the CPT codes 97002 (physical therapy re-evaluation), 97032 (electrical stimulation), and 97140 (manual therapy) were medically necessary. I also disagree with the carrier and find that the office visits (99212) dated 8/16/04, 8/20/04, 8/31/04, 9/7/04, 9/17/04, 9/24/04, 10/4/04, and 10/18/04 were medically necessary. I agree with the carrier that the remainder of the services submitted for review were not medically necessary.

## **Rationale/Basis for Decision**

According to the supplied documentation, the claimant sustained an injury to his right foot on \_\_\_\_. After no improvement of his initial care, the claimant switched treating doctors and began care. With the type of injury that occurred and the pain associated with it, passive therapies are seen as reasonable and medically necessary to help reduce pain and prevent further restriction. The manual therapy code that would help induce range of motion and help prevent atrophy is considered appropriate in the treatment of the compensable claim. Weekly office visits that would help determine the claimant's condition are also medically necessary to help determine referrals, work status reports, and any associated home exercise protocols. The remainder of the therapy submitted for review is not considered reasonable or medically necessary. The initial foot and ankle consult with Anthony J. Lamarra, D.P.M. reveals the claimant did have a fracture of the right foot. Therapeutic exercises that were listed in the therapy notes include activities that would be contraindicated with a fracture. Designated doctor report on 9/10/04 with Edid G. Ramos-Rivas stated the claimant's prior therapies including medications and physical therapy had failed and would consider the claimant to be a surgical candidate. When the referral podiatrist and the designated doctor both concurred that the claimant was a surgical candidate, continued and ongoing therapeutic exercises were not indicated and are not considered appropriate in the treatment of the compensable injury.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to DWC via facsimile or U.S. Postal Service from the office of the IRO on this 19<sup>th</sup> day of September 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder