



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:
Integra Specialty Group, P.A.
517 North Carrier Parkway Suite G
Grand Prairie, Texas 75050

MDR Tracking No.: M5-05-3250-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:
Assurance Company of America
Box 19

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60 dispute package.

POSITION SUMMARY: Per table of disputed services "Medically necessary".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60 package

POSITION SUMMARY: This case involves DOS 11/22/04 through 04/27/05 and has \$5,051.07 in dispute. Carrier preauthorized ten sessions of work hardening effective from 12/28/04 through 01/31/05. All services provided that were not in compliance with this authorization were denied as not medically necessary per the carrier's peer advisor ("V").

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
11-22-04 to 04-18-05	99213, 97032, 97035, 97140, 97110, 97012, 97750-FC, 95831 and 96004	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00

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 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 09-13-05, 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.

On 10-10-05 the Requestor withdrew dates of service 11-22-04 and 11-29-04.

Review of CPT code 97140 dates of service 12-07-04, 12-13-04, 12-20-04, 12-27-04, 02-14-05, 02-18-05, 04-04-05, 04-08-05, 04-22-05, 04-25-05 and 04-27-05 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for EOBs. Reimbursement is recommended in the amount of **\$375.43**.

Review of CPT code 99213 dates of service 12-07-04, 12-13-04, 12-20-04, 12-27-04, 02-14-05, 02-18-05, 04-04-05, 04-08-05, 04-22-05, 04-25-05 and 04-27-05 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for EOBs. Reimbursement is recommended in the amount of **\$750.64**.

Review of CPT code 97032 (2 units each DOS) for dates of service 12-27-04, 04-04-05, 04-08-05, 04-20-05, 04-22-05, 04-25-05 and 04-27-05 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for EOBs. Reimbursement is recommended in the amount of **\$282.80**.

Review of CPT code 97035 for dates of service 12-27-04, 04-04-05, 04-08-05, 04-20-05, 04-22-05, 04-25-05 and 04-27-05 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for EOBs. Reimbursement is recommended in the amount of **\$110.88**.

Review of CPT code 97110 (3 units for each date of service with the exception of 04-27-05 which 2 units were billed) for dates of service 04-08-05, 04-20-05, 04-22-05, 04-25-05 and 04-27-05 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for EOBs. Per Rule 133.307(g)(3)(A-F) the Requestor provided documentation to support the services billed. Reimbursement is recommended in the amount of **\$517.86**.

CPT code 97545-WH dates of service 01-04-05 and 01-05-05 were denied with denial code "V" (unnecessary treatment with peer review). The services had been preauthorized. Reimbursement is recommended in the amount of **\$204.80**. A Compliance and Practices referral will be made as the carrier is in violation of Rule 134.600.

CPT code 97546-WH dates of service 01-04-05 and 01-05-05 were denied with denial code "V" (unnecessary treatment with peer review). The services had been preauthorized. Reimbursement is recommended in the amount of **\$614.40**. A Compliance and Practices referral will be made as the carrier is in violation of Rule 134.600.

CPT code 97140 date of service 03-04-05 denied with denial code "W1/28" (Denied treatment no longer appropriate for injury). Per Rule 133.307(g)(3)(A-F) the Requestor provided documentation to support the service billed. Reimbursement is recommended in the amount of **\$34.13**.

CPT code 97750-FC date of service 03-04-05 denied with denial code "W1/28" (Denied treatment no longer appropriate for injury). Per Rule 133.307(g)(3)(A-F) the Requestor provided documentation to support the service billed. Reimbursement is recommended in the amount of **\$296.40**.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and Rules 133.307(e)(2)(B), 133.307(g)(3)(A-F) and 134.600

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 reimbursement in the amount of \$3,187.34. The Division finds that the requestor was not the prevailing party and is not entitled to a refund of the IRO fee. 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.

Ordered by:

12-14-05

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.



CompPartners Final Report ACCREDITED INTERNAL REVIEW

CompPartners Peer Review Network
Physician Review Recommendation
Prepared for TDI/DWC

Claimant Name:

Texas IRO # :

MDR #: M5-05-3250-01

Social Security #:

Treating Provider: Patrick Downey, DC

Review: Chart

State: TX

Review Data:

- Notification of IRO Assignment dated 9/12/05, 1 page.
- Receipt of Request dated 9/12/05, 1 page.
- Medical Dispute Resolution Request/Response dated 8/16/05, 2 pages.
- List of Treating Providers (date unspecified), 1 page.
- Table of Disputes dated 4/27/05, 4/25/05, 4/22/05, 4/20/05, 4/18/05, 4/14/05, 4/11/05, 4/8/05, 4/6/05, 4/4/05, 3/23/05, 3/4/05, 2/18/05, 2/14/05, 1/5/05, 1/4/05, 12/27/04, 12/20/04, 12/13/04, 12/7/04, 12/1/04, 11/29/04, 11/22/04, 4 pages.
- Explanation of Benefits dated 5/17/05, 5/4/05, 4/12/05, 3/17/05, 2/14/05, 12/31/04, 7 pages.
- Order for Payment of Independent Review Organization Fee dated 9/30/05, 1 page.
- IRO Provider Position Statement dated 9/30/05, 1 page.
- Examination dated 3/31/05, 2 pages.
- Prescription dated 3/31/05, 1 page.
- Non-Authorization Notice (date unspecified), 1 page.
- Authorization After Reconsideration Notice dated 2/25/05, 1 page.
- Physical Therapy Exercises (date unspecified), 6 pages.
- Facsimile Transmittal dated 9/16/05, 9/14/05, 9/12/05, 7 pages.
- Fax Confirmations dated 9/16/05, 9/14/05, 9/12/05, 7 pages.

Reason for Assignment by TDI/DWC: Determine the medical necessity of the previously denied office visits, electrical stimulation, ultrasound, manual therapy technique, therapeutic exercises, mechanical traction, functional capacity examination, muscle testing extremity, physician review/interpretation of comprehensive computerized based motion analysis, with dates of service from 11/22/04 to 4/18/05.

Determination: UPHELD – previously denied office visits, electrical stimulation, ultrasound, manual therapy technique, therapeutic exercises, mechanical traction, functional capacity examination, muscle testing extremity, physician review/interpretation of comprehensive computerized based motion analysis, with dates of service from 11/22/04 to 4/18/05.

Rationale:

Patient's age:

Gender:

Date of Injury: ____

Mechanism of Injury: Not stated for this review.

Diagnosis: Left shoulder acromioclavicular pain.

This patient was treated with chiropractic care, medication, physical therapy and exercises, as well as indications of local joint injections and a left shoulder arthroscopic surgery, without mention of the date this took place. The only clinical information provided for this patient's dispute resolution was found on a 3/31/05 update report from American Orthopedic and Neurological Rehabilitation Centers, Joseph Daniels, DO, an orthopedic surgeon. The patient had received an injection on 3/23/05 to the

acromioclavicular (AC) joint, and the patient reported that it helped a great deal for about three days, and then the pain gradually returned with any type of rotation, causing crepitation and increase in pain. X-rays of the shoulder revealed a type II acromion. Clinical examination revealed active range of motion of the left shoulder to be restricted, and there are no degrees mentioned. There was tenderness to palpation of the subacromial bursa, particularly, acromioclavicular pain. Apprehension test was negative. Relocation was negative. Sulcus was negative. Yergason's was negative. Hawkins was positive. Muscle strength was documented as normal, and the muscle group of the shoulder joint was +4/5. There was no atrophy. There was negative Adson's test. Positive for crepitation. Negative for edema of the bilateral upper extremities. He recommended the patient have an acromioclavicular joint resection surgery procedure performed as his best alternative. The patient will be scheduled for this arthroscopic procedure. There was a prescription provided by this orthopedic specialist for recommendation for physical therapy/rehabilitation, three times weekly for five weeks, with Dr. Murphy, DC. The other information provided indicated that this claimant was approved for seven sessions of work hardening for dates of service 2/23/05 to 3/18/05 as approved by Gary Polizzotto, DC, after a reconsideration review. The work hardening does not appear to be part of this disputed item list but work hardening would normally be conducted after a surgical procedure, not before. The question presented to this reviewer is to determine the medical necessity for appeal of services from 11/22/04 to 4/18/05 for items marked V and W9. Items in dispute include office visits, electrical stimulation, ultrasound, manual therapy technique, therapeutic exercises, mechanical traction, functional capacity examination, muscle testing extremity, physician review interpretation of comprehensive computerized based motion analysis. Overall, the requested physical therapy/rehabilitation, for 3 times per week for five weeks, does not appear to be a medical necessity. This patient was being scheduled for surgery for the AC joint and he has had an excessive number of physical therapy/rehabilitation visits with no apparent clinically documented improvements of function or subjective complaint provided for this review. The IRO Provider Position Statement, dated 9/30/2005, argues that the 15 visits under review were "to resolve restricted ROM in the shoulder, reduce inflammation and relieve pain." If, in fact, such treatment were to be successful, there would be no need for the surgery. The decision for surgery was made on the basis that conservative treatment had failed to resolve the problems in the shoulder. There was no reasonable expectation that the disputed treatment would be successful when prior attempts at non-operative treatment had failed. He was only better after the injection from 3/23/05, but pain returned and subsequent recommendation for surgery was made. There was no medical necessity for the disputed treatment.

Criteria/Guidelines utilized: TWCC rules and regulations. ACOEM Guidelines, 2nd Edition, Chapter 9.

Physician Reviewers Specialty: Chiropractic

Physician Reviewers Qualifications: Texas Licensed DC, BSRT, FIAMA Chiropractor and is also currently listed on the TWCC ADL list.

CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for the decision before the referral to CompPartners, Inc.

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.