



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> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address:  Summit Rehabilitation Centers 2500 W. Freeway #200 Ft. Worth, TX 76102	MDR Tracking No.: M5-05-3270-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address:  Liberty Mutual Fire Insurance, Box 28	Date of Injury: Employer's Name: Insurance Carrier's No.:

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

Documents include DWC 60 form, Explanations of Benefits, medical documentation and CMS 1500's. Position summary states, "Services were necessary to treat the injured worker."

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

Documents include DWC 60 form and Explanations of Benefits. Position summary states, "We base our payment on the Texas Fee Guidelines and the Texas Workers' Compensation Commission Acts and Rules."

#### 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)
8-16-04 – 5-25-05	CPT codes 97110 (3 units per date of service) (\$110.97 X 6 DOS + \$108.42 x 10 DOS) 99213 (\$68.24 X 19 DOS + \$68.31 X 17 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$4,207.85
8-16-04 – 5-25-05	CPT codes G0283, 99090, 96004, 95851, 95833, 98940, 97140, 97140-59, 97012, 99199, 97110 (more than 3 units per date of service)	<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. The amount due the requestor for the items denied for medical necessity is \$4,207.85.

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.

In a letter dated 12-5-05 the requestor withdrew date of service 9-28-04. This service will not be a part of this review. On 10-18-05 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 97750-FC on 8-20-04 was denied as "F – Fee Guideline MAR dispute." The carrier states that it has reimbursed the requestor for four FCE's as follows: 3-3-04 (4 hours), 4-30-04 (4 hours), 5-7-04 – (2 hours) and 8-20-04 (2 hours). Rule 134.202 (e)(4) states: "A maximum of three FCE's for each compensable injury shall be billed and reimbursed." The requestor submitted no documentation supporting the necessity of this FCE. Recommend no reimbursement.

Regarding CPT code 97012 on 12-9-04: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). Recommend reimbursement of \$19.21.

Regarding CPT code 97110 on 12-9-04: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). The requestor provided documentation to support delivery of services and one-on-one treatment per Rule 133.307(g)(3)(A-F). Recommend reimbursement of \$147.96.

Regarding CPT code 97140 on 12-9-04: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). Recommend reimbursement of \$34.13.

Regarding CPT code 99213 on 12-9-04: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). Recommend reimbursement of \$68.24.

Regarding CPT code G0283 on 12-9-04: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). Recommend reimbursement of \$14.41.

CPT code 95833 on 12-13-04 was denied by the carrier as "N – documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge." The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Reimbursement of \$44.99.

CPT code 96004 on 12-13-04 was denied by the carrier as "N – documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge." The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Reimbursement of \$152.75.

CPT code 97012 on 12-13-04 was denied by the carrier as "N – documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge." The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Reimbursement of \$19.21.

CPT code 97110 on 12-13-04 was denied by the carrier as "N – documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge." The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Reimbursement of \$147.96.

CPT code 97140-59 on 12-13-04 was denied by the carrier as "N – documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge." The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Reimbursement of \$34.13.

CPT code 98940 on 12-13-04 was denied by the carrier as "N – documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge." The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Reimbursement of \$33.61.

CPT code 99213 on 12-13-04 was denied by the carrier as “N – documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge.” The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Reimbursement of \$68.24.

CPT code G0283 on 12-13-04 was denied by the carrier as “N – documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge.” The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Reimbursement of \$14.41.

CPT code 95851 on 12-21-04 was denied by the carrier as “G-procedure is mutually exclusive to another on the same date of service.” CPT code 95851 is considered by Medicare to be a component procedure of CPT code 99213. There are no circumstances in which a modifier would be appropriate. The services represented by the code combination will not be paid separately.

CPT code 99199 on 11-4-04, 1-11-05 and 4-12-05 and 5-12-05 was denied by the carrier as “N – documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge.” The requestor did not provide documentation to support delivery of services per Rule 133.307(g)(3)(A-F). No reimbursement is recommended.

Regarding CPT code 99213 on 4-22-05: Neither the carrier nor the requestor provided EOB’s. The requestor submitted convincing evidence of carrier receipt of provider’s request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB’s per rule 133.307(e)(3)(B). Recommend reimbursement of \$68.31.

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

28 Texas Administrative Code Sec. 133.308 and Rule 134.202 and 133.307.

#### **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 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 \$5,075.41. 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 by:**

_____	Donna Auby	12-19-05
_____	Margaret Ojeda, Manager, Medical Necessity Team	12-19-05
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.

Amended Report 12-12-2005

November 9, 2005

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

Patient:  
DWC #:  
MDR Tracking #: M5-05-3270-01  
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI-Division of Workers' Compensation has assigned this case to Specialty IRO for independent review in accordance with DWC 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 DWC 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

The records that were received and reviewed indicated that \_\_\_ was working for Brinker International/Maggiano's as a prep cook when he was injured. The patient was injured on \_\_\_ while carrying a bin of bread weighing approximately 30-40 pounds when he slipped on a wet floor and fell backward onto his buttocks injuring his lower back. The patient initially complained of back pain with pain radiating down his legs. The patient underwent care including conservative care, epidural steroid and facet injections, and medications.

#### RECORDS REVIEWED

Letter from Liberty Mutual  
Case summary from Virginia Cullipher  
George Armstrong MD  
Glenn Robinson DC  
PRI reviews, multiple  
Marivel Subia DC  
Atlantis Healthcare  
Todd Petersen DC  
Summit Rehab Centers  
DD Report by Dr. Inthanousay, not at MMI on 09-04-2004 and 05-27-2005

DFW Pain Consultants  
Metroplex Orthopedics  
North Dallas Diagnostic Center  
Bryce Benbow DO

## DISPUTED SERVICES

The items in dispute are the retrospective medical necessity of 97012-mechanical traction, 98940-chiropractic manipulation, 99213-office visits, 99090-analysis of clinical data ROM, 97140, 97140-59-manual therapy technique, 96004-physician review and interpretation of comprehensive computer based motion analysis, 99199-special service, 95833-muscle test, 95851-ROM, G0283-electrical stimulation and 97110 therapeutic exercises from 8/16/2004 through 5/25/2005.

## DECISION

The reviewer agrees with the previous adverse determination regarding G0283 Electrical Stimulation, 99090 Analysis of Clinical Data, 96004 Physician review and interpretation of comprehensive computer based motion analysis, 95851 Range of Motion, 95833 Muscle Test, 98940 Chiropractic Manipulation, 97140(97140-59) Manual Therapy Technique, 97012 Mechanical Traction, and 99199 Special Services.

The reviewer disagrees with the previous adverse decision regarding 97110 Therapeutic Exercises for up to three units for the dates under review. The reviewer agrees with the previous adverse decision regarding 97110 Therapeutic Exercises for more than three units for any date of service under review. In other words, up to three units of 97110 for each date of service under review should be approved.

The reviewer disagrees with the previous adverse decision regarding 99213 Office Visits.

## 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. It should also be noted that throughout the course of rehabilitative exercises under review, the patient made minimal gains as evidenced by treatment protocol documentation. For example on 8-5-2004, the patients measured ranges of motion are 27 and 26 for left and right lateral lumbar flexion—which are normal—and then later measured on 10-4-2004 at 21 and 28 respectively showing a worsening of the patient condition. Flexion and extension were measured at 55 and 29 on 8-5-2004 and then later measured at 47 and 12 on 10-4-2004. There should be a much more significant gain in the patient's treatment protocol but the patient did undergo invasive procedures, which could account for the necessity of continued rehabilitative exercises. The documentation does not support the continued need of passive therapies or manual treatment measures 8-15 months after the initial injury. In addition, it would exceed the 45-minute timeframe. It should also be noted that the Designated Doctor on 09-04-2004 and 05-27-2005 did not place the patient at MMI.

The MDA gives approximately 3 months for the duration of length of disability for this type of injury as identified below, but the patient had a complicating condition of lumbar disc disease. The patient also underwent numerous invasive procedures, which would require post rehabilitative care for each procedure. In regards to the range of motion testing and muscle testing of the patient and the analysis and review of the same data, there is no documented change in the treatment plan after the testing and no rationale given for performing these services. There is also no clinical necessity or adequate documentation for the special services. The office visits would be appropriate to monitor and evaluate the patient's care and to determine a treatment protocol for the patient.

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 the reviewing provider has no known conflicts of interest 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 decision before referral to the IRO.

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 DWC- Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the via facsimile, U.S. Postal Service or both on this 12<sup>th</sup> day of December 2005**

**Signature of Specialty IRO Representative:**

**Name of Specialty IRO Representative: Wendy Perelli**