



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.: M5-05-3287-01
SCD Back and Joint Clinic, Ltd. 200 E. 24 th Street, Suite B Bryan, Texas 77803	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:
Liberty Mutual Fire Insurance, Box 28	

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included TWCC 60 form, Explanations of Benefits, medical documentation and CMS 1500's. Position summary states, "It is our position that these services were reasonable, necessary and related to the compensable injury. Appeals and follow up with the carrier have failed to resolve the dispute."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No position paper 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)
12-10-04 and 1-11-05	CPT code 99212	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$83.82
12-15-04	CPT code 99213	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$58.99
11-24-04 – 1-11-05	CPT codes 98940, 99211-25, 97124, 97112, 97110, 97530, 97150, G0283, 97018	<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 not prevail on the majority of the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$142.81.

In a letter dated 9-26-05 the requestor withdrew dates of service 10-6-04, 10-7-04 and CPT code 97750 on 12-10-04. These services will not be a part of this review.

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 Division has determined that the requestor is entitled to additional reimbursement in the amount of \$142.81 for the services involved in this dispute and is not entitled to a refund of the paid 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.

Findings and Decision by:

Authorized Signature

Typed Name

10-13-05

Date of Findings and Decision

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 3, 2005

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

Patient:
TWCC #:
MDR Tracking #: M5-05-3287-01
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

Ms. ___ was injured on ___ while working for _____. The records indicate she suffered a repetitive motion injury, which came to a head when she was gripping a hose for long periods of time. She treated for several months with physical therapy. She changed treating doctors to John Wyatt, DC. She had right carpal tunnel surgery on 8/30/04. The records indicate she had a left CTS release; however, it does not provide a date on which it was performed. She underwent post surgical rehabilitation and was placed at MMI on 11/19/04 by Joseph Iero, MD with 2% WP impairment. The treating doctor agreed with this assessment. She was returned to light duty work on 9/24/04. She was returned to full duty work on 12/13/04.

RECORDS REVIEWED

Records were received and reviewed from the requestor/treating doctor and from the respondent. Records from the requestor/TD include the following: 9/21/05 letter from John Wyatt, DC, 9/21/04 subsequent medical report, TWCC 73's of various dates, 9/21/04 wrist (L and R) ROM reports, 10/19/04 amended subsequent medical narrative report (SMNR), 9/30/04 and 10/14/04 therapy scripts, 12/10/04 SMNR, 10/21/04 through 11/23/04 muscle strength testing report, exercise grid from 9/24/04 through 12/08/04, form T0274.70 from 9/24/04 through 12/08/04, form T0274.71 from 10/25/04 through 12/08/04, SOAP notes by Dr. Wyatt from 9/14/04 through 01/11/05, 8/30/04 operative report by George Richardson, MD, follow up notes by Dr. Richardson from 9/3/04 through 01/14/05, 12/8/04 referral script to Rani Cherian, MD, DD report by Joseph Iero, MD of 11/19/04 and IRO submission appendices A-F.

Records from the respondent include some of the above in addition to the following: 9/27/05 letter by Virginia Cullipher, RN, handwritten summary of treatment sheet, 1/31/05 chiropractic modality review by George Sage, DC, 6/23/04 chiropractic modality

review by Harry Morgan, DC, computerized screen report dated 5/18/05 and 3rd major revision post operative treatment plan dated 11/23/04.

DISPUTED SERVICES

Disputed services include 98943, 99212, 99213, 99211-24, 97124, 97112, 97110, 97530, G0283, and 97018 from 11/24/04 through 1/11/05.

DECISION

The reviewer disagrees with a previous adverse determination regarding the following services on the following dates: 99212 (12/10/04, 1/11/05) and 99213 (12/15/04).

The reviewer agrees with the previous adverse determination regarding all remaining services.

BASIS FOR THE DECISION

The reviewer indicates that the treating doctor agreed with the designated doctor that the patient had reached "Clinical MMI" as defined by the Texas Labor Code and by the TWCC rules (130.1) on 11/19/04. It is not unusual for a patient to require further treatment in support of any exacerbations, which are related to the original injury. The patient's pain scale remained at a three out of ten from mid November through January of 2005 when it rose to a 4/10.

Upon reviewing the 12/10/04 PPE examination, it is interesting that the right-sided grip strength was measured at 0 lbs at all levels. Her pinch levels were very low. This would appear to indicate a lack of effort in a patient who is two months post surgical at this point. Range of motion was extremely limited during this examination. If one is to compare the ROM as performed by the treating doctor to that done by the designated doctor it indicates a greater than 75% reduction (in most planes of movement) when performed on 12/10/04.

Utilizing the book by Brotzman, Wilk, Clinical Orthopaedic Rehabilitation, Mosby, 2003, Second Edition, this indicates that approximately four weeks of post surgical rehabilitation is required. The patient had scripts for four weeks of therapy that were provided with the documentation. It is true that complications and exacerbations may be experienced. However, these were not indicated during the period that was under treatment.

Regarding the IRO submission Appendices A-F, a lot of the studies they list relate to lower back pain or diagnoses that do not relate to this condition. The reviewer indicates agreement with the need for one on one rehabilitation in most cases of spinal or extraspinal injury. However, the treating doctor agreed that the patient was at MMI as stated above. Therefore, as per TWCC rules, all treatment performed after this would be reasonable and necessary if related to an exacerbation. No exacerbations were noted in the records provided by any party. Office visits were approved to allow the treating doctor to follow up on the patient and ensure her re-integration into the workforce.

Post-surgical extremity manipulation is not supported by the documentation provided. Therapeutic exercises, therapeutic activities and therapeutic procedures were well documented in the provided documentation; however, the patient had reached MMI and did not appear to have reduction of pain, increase of functionality and/or return to work as a direct result of the treatment under review.

According to the Medical Disability Advisor by Presley Reed, MD, the time frames for disability following an open or endoscopic release are noted below:

Open or endoscopic surgery.

Job Classification	Minimum	Optimum	Maximum
<i>Sedentary</i>	7	14	42
<i>Light</i>	14	28	42
<i>Medium</i>	14	35	56
<i>Heavy</i>	28	42	84
<i>Very Heavy</i>	28	56	84

REFERENCES

TWCC Rules 130.1, 130.5 and 130.6; TLC 408.021

ACOEM Guidelines

Brotzman, Wilk, Clinical Orthopaedic Rehabilitation, Mosby, 2003, Second Edition

Reed, P Medical Disability Advisor, 2003, Internet

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