



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.: M5-05-3288-01
Summit Rehabilitation Centers 2500 W. Freeway #200 Ft. Worth, TX 76102	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:
Sierra Insurance Co of Texas, Box 17	

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include DWC 60 form, Explanations of Benefits and CMS 1500's. Position summary states, "All participants shall be responsible for correctly applying the ground rules contained within the Medical Fee Guideline, and the rules contained within the CPT/HCPCS, the ICD-9-CM coding system and the global service surgery coding guidelines."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include DWC 60 form, Explanations of Benefits and CMS 1500's. Position summary states, "The Requestor is not entitled to any additional reimbursement in this matter as they have performed treatment that was deemed medically unnecessary."

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)
1-17-05 – 3-18-05	CPT codes 97018, 95851, G0283, 97750-FC, 95831, 95832, 95833, 96004, 97140, 97110, 99354	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$5,987.46
4-11-05 – 5-13-05	CPT codes 97018, 95851, G0283, 97750-FC, 95831, 95832, 95833, 96004, 97140, 97110, 99354	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
2-11-05	CPT code 97012	<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 majority of the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$5,987.46.

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 9-29-05 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.

Per Rule 134.6 CPT code 99082 on 1-18-05, 3-7-05 and 3-9-05 will not be reviewed by the Medical Dispute Resolution Division.

CPT code 99080-73 on 2-25-05 was denied for medical necessity. The office visit on this date was found to be medically necessary. The DWC-73 is a required report per Rule 129.5. The Medical Review Division has jurisdiction in this matter; Recommend reimbursement of \$15.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec 129.5, 133.308 and Rule 134.202(c)(1) and 134.6.

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) 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 \$6,002.46. 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.

Finding and Decision by:

_____	Donna Auby	12-16-05
Authorized Signature	Typed Name	Date of Finding and Decision

Order by:	Margaret Ojeda, Manager, Medical Necessity Team	12-16-05
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_____	_____	_____
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.

October 24, 2005

TX DEPT OF INS DIV OF WC
AUSTIN, TX 78744-1609

CLAIMANT: ____

EMPLOYEE: ____

POLICY: M5-05-3288-01

CLIENT TRACKING NUMBER: M5-05-3288-01/5278

AMENDED DECISION 12/06/05

Medical Review Institute of America (MRIoA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Department of Insurance Division of Workers' Compensation has assigned the above mentioned case to MRIoA for independent review in accordance with DWC Rule 133 which provides for medical dispute resolution by an IRO.

MRIoA has performed an independent review of the case in question 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. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the DWC approved doctor list (ADL). 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.

Records Received:

Records From The State:

Notification of IRO assignment – 2 pages

Medical Dispute Resolution Request/Response – 2 pages

Disputed Items List – 6 pages

EOBs – 11 pages

Records From the Respondent:

Letter from Downs – Stanford PC to MRIoA dated 10/4/05 – 2 pages

History and Physical – 3 pages

Addendum to History and Physical – 1 page

Records From the Requestor:

Doctor's Position Statement for IRO Regarding Medical Necessity Denial – 2 pages

CT Scan of the Left Wrist – 1 page

MRI of the Left Wrist – 1 page

Chart Notes – 147 pages

Operative report – 2 pages

Range of Motion Exam – 29 pages

Range of Motion History – 21 pages

ERGOS Evaluation Summary Report – 51 pages

Notice of Pre-Authorization – 2 pages

DWC Status Report – 1 page

Request for Reconsideration – 2 pages

RHD Hand/Wound Center Prescriptions – 1 page

Duplicate Records – 24 pages

Summary of Treatment/Case History:

The patient was injured lifting an oversized piece of metal with a co-worker when he felt a sharp pain in the left wrist that was witnessed by his manager. The patient went through active and passive therapy with the chiropractor and he plateaued in care. He was referred for a left wrist MRI study on 6/7/04 that revealed the suggestion of a nondisplaced fracture of the lunate. A differential diagnosis was early avascular necrosis of the lunate. The patient underwent a left wrist CT scan on 6/18/04 that revealed an intact lunate. A 3 mm cyst was noted in the lunate and the patient was differentially diagnosed with chondromalacia with reactive hyperemia and also stage I avascular necrosis of the lunate.

The patient was referred to Robert Ippolito MD for an orthopedic consultation on 8/6/04 and he was diagnosed with carpal tunnel syndrome and possible avascular necrosis of the lunate. Arthroscopy and possible fusion was recommended. The patient was re-examined by Dr. Ippolito on 10/14/04 and he was diagnosed with avascular necrosis of the lunate.

The claimant underwent a required medical evaluation with Rebecca Schmidt MD on 10/25/04 and she opined that no further chiropractic care was indicated and the patient should be referred to a hand surgeon for further evaluation. She also indicated that no further FCE's were required unless the patient was to undergo surgical intervention.

The patient underwent left wrist surgery for Keinbock's disease on 11/24/04 that consisted of revascularization of the lunate bone with a microvascular graft. The patient was seen for a follow-up evaluation on 12/6/04 and he was given a splint. Dr. Ippolito re-evaluated the patient on 12/20/04 and he was to continue with splint usage. The patient was referred for physical therapy/occupational therapy on 1/13/05 at a frequency of 3 times per week for three weeks with Dr. Subia (chiropractor).

The patient was treated by the chiropractor on the following dates with manual therapy (#97140), therapeutic exercises (#97110), paraffin bath (#97018), and unattended electrical stimulation (#G0283):

1/17/05, 1/18/05, 1/20/05, 1/21/05, 1/24/05, 1/27/05, 1/28/05, 1/31/05, 2/2/05, 2/4/05, 2/7/05, 2/9/05, 2/11/05, 2/14/05, 2/16/05, 2/18/05, 2/21/05, 2/23/05, 2/25/05, 2/28/05, 3/7/05, 3/9/05, 3/14/05, 3/16/05, 3/18/05, 5/4/05, 5/5/05, 5/6/05, 5/9/05, 5/10/05, and 5/13/05.

The records reviewed indicated that the chiropractor billed for physician review of computer data (#96004) on the following dates: 1/17/05, 1/28/05, 2/2/05, 2/7/05, 2/14/05, 2/21/05, 3/1/05, 3/14/05, and 4/11/05. A review of the chart notes revealed a one line entry referring to the doctor's review of the records, but no extensive documentation related to the review, which was billed at \$155.00 was revealed in the records reviewed. The documents reviewed consisted of range of motion studies and muscle testing studies conducted over the course of the patient's treatment.

The patient underwent range of motion studies (#95831) on the following dates: 1/17/05, 1/28/05, 2/7/05, 2/21/05, and 3/14/05. The patient underwent muscle-testing studies (#95831, #95832, and #95833) on the following dates: 1/17/05, 2/2/05, 2/14/05, and 3/7/05.

The patient underwent mechanical traction (#97012) on 2/11/05.

Combined muscle testing/range of motion studies were done on 4/19/05 and 5/31/05 that were not included as items in dispute in this case. The patient was re-examined by Dr. Ippolito on 2/3/05 and additional therapy was prescribed. He was also evaluated by Dr. Ippolito on 2/24/05 and no additional therapy was recommended at that time.

The patient underwent a functional capacity evaluation on 3/1/05 and a short course of work hardening was recommended. A preauthorization request was submitted for four weeks of work hardening on 3/11/05, which was modified to approval of a work-conditioning program. A subsequent appeal was reviewed and the patient was preauthorized for one month of work hardening to occur between 3/17/05 and 4/17/05.

The patient was re-examined by Dr. Ippolito on 3/31/05 and additional therapy was recommended based on improvements in hand/wrist function.

The patient underwent a repeat FCE on 4/16/05 and functional improvements were noted, but a chronic pain program was subsequently recommended. The 9/12/05 report from Dr. Ippolito indicated the patient's wrist function was deteriorated and sacculolunate advanced collapse was noted, and additional MRI studies were ordered.

Services from 1/17/05 through 5/13/05 were denied based on a previous peer review.

Questions for Review:

#97018 (Paraffin Bath), #98581 (ROM), #97110 (therapeutic procedures), mechanical traction (#97012), #G0283 (Electrical stimulation), #97750-FC (FCE), #95831, #95832, #95833 (Muscle Test), #96004 (Physician review of computer data), #97140 (manual therapy), #99534 (Prolonged physician services). Review all codes on all dated except #99082 and #99080-73. A sample of EOBs is attached. Dates of Service in dispute 1/17/05-5/13/05.

Explanation of Findings:

#97018 (Paraffin Bath), #98581 (ROM), #97110 (therapeutic procedures), #G0283 (Electrical stimulation), #97750-FC (FCE), #95831, #95832, #95833 (Muscle Test), #96004 (Physician review of computer data), #97140 (manual therapy), #99354 (Prolonged physician services). Review all codes on all dated except #99082 and #99080-73. A sample of EOBs is attached. Dates of Service in dispute 1/17/05-5/13/05.

The following services rendered from 1/17/05 through 3/18/05 were medically necessary for the treatment of the patient's post-surgical wrist and avascular necrosis of the lunate of the left wrist: #97018 (Paraffin bath), #95851 (Range of motion assessment), #G0283 (electrical stimulation), #97750-FC (Functional Capacity Evaluation), #95831, #95832, #95833 (muscle testing), #96004 (physician review of computer data), #97140 (manual therapy), #97110 (therapeutic procedures), #99354 (prolonged physician services).

The denials in this case were based on an RME/peer review report done on 10/24/04, which was prior to the patient's surgery. The RME report recommended no further chiropractic treatments of the patient's wrist, but did recommend possible post-operative treatments and FCEs.

The patient in this case did not receive manipulation treatments of the wrist, but did receive post-operative physical therapy care consisting of passive modalities, active rehabilitation treatments, range of motion studies, muscle testing studies, and two functional capacity evaluations. The patient in this case was referred by the hand surgeon to the chiropractor for additional physical therapy/rehabilitation treatments. The Hand-Wrist Guidelines from MedRisk indicate that up to 28 sessions of physical therapy are indicated for physical therapy management of a post-operative condition related to the hand or wrist (Expert Clinical Benchmarks, Hand-Wrist, King of Prussia, PA, MedRisk, Inc. 2004).

The patient underwent a functional capacity evaluation on 3/1/05 and a short course of work hardening was recommended. A preauthorization request was submitted for four weeks of work hardening on 3/11/05, which was modified to approval of a work-conditioning program. A subsequent appeal was reviewed and the patient was preauthorized for one month of work hardening to occur between 3/17/05 and 4/17/05.

Dates of service after 3/18/05 were not medically necessary in this case due to the fact that the patient had been through a work hardening program and medical necessity for the additional care was not demonstrated by records reviewed. The care rendered after 3/18/05 (dates of service from 5/4/05 through 5/13/05) were not medically necessary, as they represented a return to less intensive physical therapy treatments rendered after the work hardening program that were not supported by documentation provided for review. The records reviewed contained no data related to the patient's performance in the one-month work hardening program. Haldeman et al indicated that the patient's records must be sufficiently complete to provide reasonable information requested by a subsequent healthcare provider, insurance company, and/or attorney. A dated record of what occurred on each visit and any significant changes in the clinical picture or assessment, or treatment plan need to be noted (Haldeman, S., Chapman-Smith, D., and Petersen, D., Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen, Gaithersburg, Maryland, 1993).

The mechanical traction (#97012) was also not medically necessary on 2/11/05. Mechanical traction is not an accepted form of treatment for carpal tunnel syndrome or a vascular necrosis.

Conclusion/Decision to Certify:

The following services rendered from 1/17/05 through 3/18/05 were medically necessary for the treatment of the patient's post-surgical wrist and avascular necrosis of the lunate of the left wrist:
#97018 (Paraffin bath), #95851 (Range of motion assessment), #G0283 (electrical stimulation), #97750-FC (Functional Capacity Evaluation), #95831, #95832, #95833 (muscle testing), #96004 (physician review of computer data), #97140 (manual therapy), #97110 (therapeutic procedures), #99354 (prolonged physician services).

Conclusion/Decision to Not Certify:

The following services rendered after 3/18/05 were not medically necessary for the treatment of the patient's post-surgical wrist and avascular necrosis of the lunate of the left wrist:
#97018 (Paraffin bath), #95851 (Range of motion assessment), #G0283 (electrical stimulation), #97750-FC (Functional Capacity Evaluation), #95831, #95832, #95833 (muscle testing), #96004 (physician review of computer data), #97140 (manual therapy), #97110 (therapeutic procedures), #99354 (prolonged physician services).

Code #97012 (mechanical traction) was not medically necessary on 2/11/05.

Applicable Clinical or Scientific Criteria or Guidelines Applied in Arriving at Decision:

Haldeman, S., Chapman-Smith, D., and Petersen, D., Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen, Gaithersburg, Maryland, 1993

References Used in Support of Decision:

Expert Clinical Benchmarks, Hand-Wrist, King of Prussia, PA, MedRisk, Inc. 2004

This review was provided by a Doctor of Chiropractic who is also a member of the American Chiropractic Academy of Neurology. This reviewer also holds a certification in Acupuncture. This reviewer has fulfilled both academic and clinical appointments and currently serves as an assistant professor at a state college, is in private practice and is a director of chiropractic services. This reviewer has previously served as a director, dean, instructor, assistant professor, and teaching assistant at a state college and was responsible for course studies consisting of pediatric and geriatric diagnosis, palpation, adjusting, physical therapy, case management, and chiropractic principles. This reviewer is responsible for multiple postgraduate seminars on various topics relating to chiropractics and has authored numerous publications. This reviewer has participated in numerous related

professional activities including work groups, committees, consulting, national healthcare advisory committees, seminars, National Chiropractic Coalition, media appearances, and industrial consulting. This reviewer has been in practice since 1986.

MRIoA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the treating provider, payer and/or URA, patient and the DWC.

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The written opinions provided by MRIOA represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to MRIOA for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Medical Review Institute of America assumes no liability for the opinions of its contracted physicians and/or clinician advisors. The health plan, organization or other party authorizing this case review agrees to hold MRIOA harmless for any and all claims which may arise as a result of this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

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