



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: <input checked="" type="checkbox"/> Health Care Provider <input type="checkbox"/> Injured Employee <input type="checkbox"/> Insurance Carrier	
Requestor's Name and Address: Pain and Recovery Clinic 6660 Airline Dr. Houston, Texas 77076	MDR Tracking No.: M5-05-3317-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Service Lloyds Insurance Company, Box 42	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 form, Explanations of Benefits and CMS 1500's.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 form. Position summary states, "Please direct all future correspondence regarding this Medical Dispute matter to the undersigned."

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)
9-17-04 – 10-29-04	3 units of CPT code 97110 for each date of service, 99212	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2,492.16
9-17-04 – 10-29-04	More than 3 units of CPT code 97110 for each date of service, 97112, 97140	<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 \$2,492.16.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 134.202(c)(1).

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 for services in the amount of \$2,492.16. 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 and Order by:

12-05-05

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 as of 11/7/2005

October 13, 2005

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

Patient:
DWC #:
MDR Tracking #: M5-05-3317-01
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The 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

Based on the records that were received, Mr. ___ was working for _____ when he was injured in a work related accident. The accident occurred on ____. Based on the records, the patient was injured when he fell from a roof approximately 14-15 feet landing on the cement and dirt. The patient sustained facial fractures, right wrist fracture, closed head injury including frontal epidural hematoma, eye injuries and multiple soft tissue injuries including cervical, thoracic and lumbar injuries. The patient initially presented to the Ben Taub hospital for his injuries and was then referred to Healthsouth for physical therapy. The patient subsequently presented to Pain & Recovery Clinic of North Houston for treatment of his injuries.

Numerous treatment notes, diagnostic tests, evaluations, and other documentation were reviewed. Records included but were not limited to the following:

- Medical Dispute Resolution paperwork
- Numerous EOB's
- Multiple TWCC forms
- Requestor's Submission Letter
- Report from Dr. Clark
- Requestor's Position Statement

Records from Harris County Hospital District

Report from Dr. Reitman
Report from Dr. Lovitt
Records from Houston Eye Associates
Records from Pain & Recovery Clinic
Reports from Dr. Jarolimek
Electrodiagnostic report from Texas Electrophysiology Services
Head CT from North Houston Imaging Center
Records from Edward Murphy
FCE report from Dr. Mitchell
Report from Denis Turboff
Report from Dr. Hood
Corvel Report
Designated Doctor report from Dr. Borcharding
Letter from Harris & Harris

DISPUTED SERVICES

The items in dispute are the retrospective medical necessity of office visits-99212, therapeutic exercises-97110, manual therapy technique-97140 and neuromuscular re-education-97112 from 9-17-2004 through 10-29-2004.

DECISION

The reviewer disagrees with the previous adverse determination regarding office visits-99212 for the dates under review.

The reviewer disagrees with the previous adverse determination regarding therapeutic exercises 97110 for three units for the dates under review. The reviewer agrees with the previous adverse determination regarding therapeutic exercises 97110 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 agrees with the previous adverse determination regarding neuromuscular re-education 97112 for each date of service under review.

The reviewer agrees with the previous adverse determination regarding manual therapy 97140 for each date of service.

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, which shows the patient, improved his weights by only 5 lbs over the course of a month. There should be a much more significant gain in the patient's treatment protocol but none the less, the patient did make some improvement. Although the patient had a documented neurological insult, the documentation does not support the use of the code 97112 for such a protracted period of time and there is insufficient progress documented in the patient's treatment protocol. In addition it would exceed the 45-minute timeframe. The manual therapy would also exceed the 45-minute timeframe allowed and performing passive stretching on a patient that is 7-8 months post injury when the patient is also currently participating in an active rehabilitation program would be inappropriate. The three units of therapeutic exercises and office visit would be medically necessary in Mr. Vera's case considering the extent of his

injuries and multiple body parts affected. In addition, due to the fact that the patient had a fracture to the wrist, his rehabilitation

would be greatly slowed and his progress would need to be closely monitored.

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

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 TDI/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 7TH day of November 2006

Signature of Specialty IRO Representative:

Name of Specialty IRO Representative: Wendy Perelli