



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.: M5-06-0009-01
The Rehab Center 18110 Midway Rd. Suite 150 Dallas, TX 75287	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
Assoc Casualty Insurance Company, Box 42	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included DWC 60 form, Explanations of Benefits, medical documentation and CMS 1500's. Position summary states, "These claims should be paid immediately and not delayed any longer. There is a violation of Rule 133.301(a): No carrier shall prospectively review medical treatments based on a physician review done prior to the date of service rendered."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No position summary 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)
12-9-04	CPT code 99244	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$223.14
1-13-05 and 4-25-05	CPT code 99215	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$270.00
1-17-05, 1-19-05, 1-24-05, 1-26-05, 1-28-05, 1-31-05, 2-2-05, 2-4-05	CPT code 97110	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2,147.84
1-28-05	CPT code 97140	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$63.58
2-18-05 and 3-3-05	CPT code 99214	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$194.80
12-9-04 – 5-23-05	CPT codes 97545, 97546, 97750-FC	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
2-18-05 – 5-23-05	CPT code 99215	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
1-18-05 – 3-9-05 (except as noted above)	CPT code 97110	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
2-4-05, 2-11-05, 2-18-05	CPT code 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 not prevail on the majority of the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$2,899.36.

Based on review of the disputed issues within the request, the 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 9-22-05 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.

Regarding CPT code 97110 on 2-25-05: 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). Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Reimbursement not recommended.

Regarding CPT codes 97546 and 97546 from 3-24-05 through 3-30-05: In accordance with Rule 134.600 (h) (4), the requestor provided a copy of the preauthorization letter dated 3-9-05 for 10 visits of a work hardening program. Carrier denied these sessions for unnecessary medical treatment. Rule 133.301 (a) states "the insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatments (s) and/or service (s) for which the health care provider has obtained preauthorization under Chapter 134 of this title." Therefore, reimbursement is recommended in the amount of \$2,080.00 in accordance with Rule 134.600. The carrier will be referred to Compliance and Practices for this violation of the rules.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and Rules 134.202(c)(1) and 134.600.

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 not entitled to a refund of the paid IRO fee. The Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute in the amount of \$4,979.36. 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:

Donna Auby

12-14-05

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 DECISION 12/13/05

October 28, 2005

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

Patient:
DWC #:
MDR Tracking #: M5-06-0009-01
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 Doctor of Osteopathy with a specialty in Orthopedics. 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 patient was injured at work on ___ while employed with HMS Wholesaler Jewelry Company. She was up on a ladder doing some inventory and when making her way down, she missed a step and fell off the ladder, twisting at an awkward angle and finally landing on her right side. She fell approximately 5 feet, suffering trauma to the right leg, right shoulder, right knee, and right arm. She also suffered a mild concussion. She denied any history of pain or headaches prior to this work-related injury.

Patient was taken to the Plano Presbyterian Emergency Room and plain X-rays of the pelvis reportedly demonstrated a fractured pelvis. An MRI of the brain obtained on the day of injury was unremarkable for acute trauma. Her initial treatment was conservative with bed rest and narcotic analgesics.

Following her acute care she saw several other physicians including chiropractors, orthopedic surgeon, and spine surgeon. Initial diagnostic studies were obtained including MRIs of the low back, left hip, pelvis, and sacrum, along with EMG/NCV studies of the upper and lower extremities. She continued with conservative care including chiropractic adjustments, physical therapy, home exercises and aquatherapy. Patient also received NSAIDs, muscle relaxants, antidepressant medications, and benzodiazepines.

EMG/NCV of 3/25/2005 revealed bilateral carpal tunnel and a right C7 radiculopathy. (Patient underwent a right carpal tunnel release in 2003.)

X-rays 7/14/2004 of the pelvis revealed a healing right superior pubic ramus.

EMG/NCV of 5/06/2004 revealed a right C6 radiculopathy.

MRI 4/20/2004 of the right shoulder revealed post surgical scarring with evidence of a rotator cuff repair.

MRI 9/1/2004 of lumbar spine revealed an HNP at L4-5.

MRI 12/3/2003 of pelvis revealed a nondisplaced fracture of the sacrum and fracture of the right superior pubic ramus.

Physical examination: Range of motion of cervical spine is decreased in side bending by 20% and Spurling Test is negative. Examination of low back shows a full range of motion, Patrick Test negative, and Piriformis test positive on the left.

The patient care was transferred to Dr. Kemp because Dr. Saul moved his office. Patient was seen on 12/9/2004 by Dr. Kemp.

RECORDS REVIEWED

A very large volume of records was obtained from all parties to this review. Approximately 10 inches of file were reviewed. The most relevant records are listed by the reviewing doctor.

Records from Carrier:

Associate Casualty Letters: 6/21/05 through 10/18/05.
R Kemp DC, Reports: 12/9/04 through 5/23/05.
R Kemp DC, FCE's: 2/7/05 and 4/4/05.
R Levy MD, Reports: 10/5/04 through 4/8/05.
Corvel Letters: 2/18/05 through 3/23/05.
M Tonn MD, Letters: 8/1/04 through 3/22/05.
Health South Report: 8/17/04.
S Reno Ph.D. Report: 3/28/05.
K Perl DO, Reports: 12/7/04 through 3/25/05.
K Perl DO, EMG: 3/25/05.
D Shalev MD, Report: 2/28/05.
J Kay MD, Report: 10/4/04.
S Stewart RN, Report: 9/30/04.
C Farrell DO, Reports: 10/30/03 through 9/23/04.
R Blair MD, EMG: 5/8/04.
B Fletcher PSY.D, Report: 10/01/03.
A Bascone DO, MRI: 4/20/04.
Corvel Letter: 5/13/2005.
Corvel, Explanation of Review from 12/9/04 through 5/23/05.

Records from Doctors/Facility:

Rehab Center Report: 10/19/05.
R Kemp DC Reports: 7/18/05, 10/19/05.
Texas Workman's Comp Reports: 5/26/05 through 8/29/05.
S Reno MD, Reports: 3/28/05, 7/22/05.
J Kay MD, Report: 7/21/05.
K Perl DO Report: 3/25/05.
D Shalev MD Report: 3/1/05.
B Saul DC, Report: 8/26/04.
FCE: 8/10/04.
J Freeman DC, Report: 9/3/03.

DISPUTED SERVICES

The disputed services include office consultation 99244, work hardening 97545, WH each additional hour 97546, office visits 99214/99215, therapeutic exercises 97110, 97140 manual therapy technique and FCE 97750-FC from 12/9/04 through 5/23/05.

DECISION

The reviewer disagrees with the previous adverse determination regarding codes: 99244 (12/9/04), 99215 (1/13/05 and 4/25/05), 97110 (1/17/05, 1/19/05, 1/24/05, 1/26/05, 1/28/05, 1/31/05, 2/2/05 and 2/4/05), 97140 (1/28/05) and 99214 (2/18/05 and 3/3/05).

The reviewer agrees with the previous adverse determination regarding all remaining codes on all remaining dates under review.

BASIS FOR THE DECISION

This patient was injured on _____. Patient had received an extensive amount of conservative care during 2003 and 2004. Patient had FCE's during this time and was at light duty. The patient was referred to Dr. Kemp on 12/9/2004 and received an extensive amount of physical therapy.

ACOEM Guidelines do not support formal physical therapy of such a long duration. This patient's injuries were over 2 years ago and patient should have progressed to a functional restoration program with self-applied modalities at home. Moreover, the ACOEM Guidelines do not support formal physical therapy of this length without fulfilling for the purposes of education, counseling, and the initiation of a home exercise program.

REFERENCES

American College of Occupational and Environmental Medicine, Practice Guidelines, 2nd Edition.

Braddom: Physical Medicine and Rehabilitation, 2nd Edition.

Brotzman & Wilk: Clinical Orthopedic Rehabilitation, 2nd Edition.

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 13th day of December 2005

Signature of Specialty IRO Representative:

Name of Specialty IRO Representative: Wendy Perelli