



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:	MDR Tracking No.: M5-06-0181-01
<b>SCD Back &amp; Joint Clinic, Ltd</b> <b>PO Box 2850</b> <b>Bryan TX 77805</b>	Claim No.:
	Injured Worker's Name:
	Date of Injury:
Respondent's Name and Address:	Employer's Name:
	Insurance Carrier's No.:
<b>Liberty Mutual Ins Box 28</b>	

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

DWC-60 package. Position Summary: The treatment/service was medically reasonable and necessary.

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

Response to DWC-60 package. Position Summary: Carrier processed payment for copies of medical records billed on 10-21-04 and corrected billing entry for date of service 4-22-04.

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
9-21-04 to 3-20-05	99211, 99212, 99213-25, 97124, 97150, 97110, 97530, 97112	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
3-28-05 to 7-6-05	99211-25 4 days x \$23.35 (< MAR) = \$93.40 99211, 99211-25 3 days @ \$23.48 (< MAR) = \$70.44 99213, 99213-25 2 days @ \$58.99 (< MAR) = \$117.98 99212 1 day @ \$41.91 (< MAR) = \$41.91 99212-25 1 day @ \$43.00 (< MAR) = \$43.00 97124 5 units x \$25.63 = \$128.15 97124 6 units x \$25.30 (< MAR) = \$151.80 97112 1 unit @ \$34.30 (< MAR) = \$34.30 97112 1 unit @ \$33.45 (< MAR) = \$33.45 97530 25 units @ 34.30 (< MAR) = \$857.50 97530 30 units @ 33.39 (< MAR) = \$1,001.70 97750 (Human performance test) 5 units x \$33.40 (< MAR) = \$167.00 97750 (muscle testing) *see note below 97150 and 97110 (not disputed during this time frame)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2740.63
9-21-04 to 7-6-05	97012, 98940, 98943, 95851, G0283, 97139-EU, E1399	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
	TOTAL		\$2,740.63

#### 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 **prevailed** on the majority of the disputed medical necessity issues.

\*Although the IRO deemed the 97750 (muscle testing) billed on 5-17-05 & 6-27-05 as medically necessary, the requestor billed the muscle testing incorrectly; therefore, no reimbursement can be recommended.

Carrier provided proof of payment for 99080 billed on 10-21-04; therefore, this DOS will not be reviewed.

Based on review of the disputed issues within the request, Medical Review 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 10-20-05, Medical Review submitted a Notice to the 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.

Code 99080-73 billed on dates of service 10-19-04 and 5-13-05 was denied as unnecessary medical. Since the office visit on 10-19-04 was found to be not medically necessary by the IRO, then the DWC-73 report is not medically necessary. The office visit on 5-13-05 was found to be medically necessary by the IRO, then the DWC-73 report is medically necessary. Recommend reimbursement of \$15.00 for one report only. The IRO decision is a Division decision per rule 133.308(p)(5).

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

28 Texas Administrative Code Sec. 133.308, 134.202

**PART VII: DIVISION DECISION AND ORDER**

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 \$2,740.63. In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of \$460.00. 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.

Ordered by:

Medical Dispute Officer

1-25-06

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.**

# IRO America Inc.

**An Independent Review Organization  
7626 Parkview Circle  
Austin, TX 78731  
Phone: 512-346-5040  
Fax: 512-692-2924**

November 28, 2005

TDI-DWC Medical Dispute Resolution  
Fax: (512) 804-4868

Patient:

TDI-DWC #:

MDR Tracking #:

IRO #:

M5-06-0181-01

5251

IRO America Inc. (IRO America) has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI, Division of Workers' Compensation (DWC) has assigned this case to IRO America for independent review in accordance with DWC Rule 133.308 which allows for medical dispute resolution by an IRO.

IRO America has performed an independent review of the proposed care 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.

The independent review was performed by a matched peer with the treating doctor; the Reviewer is a credentialed Panel Member of IRO America's Medical Knowledge Panel who is a licensed Provider, board certified and specialized in Chiropractic Care. The reviewer is on the DWC Approved Doctor List (ADL).

The IRO America Panel Member/Reviewer is a health care professional who has signed a certification statement stating that no known conflicts of interest exist between the Reviewer 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 carriers health care

providers who reviewed the case for decision before referral to IRO America for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

## RECORDS REVIEWED

Notification of IRO Assignment, records from the Requestor, Respondent, and Treating Doctor(s), including:

1. Medical Dispute Resolution Request.
2. Table of Disputed Services.
3. Explanation of Payments from Liberty Mutual.
4. Order for Production of Documents.
5. RME by Hugh Ratliff, M.D., 1-16-04 and 10-26-04.
6. Operative report, 4-30-04.
7. ROM assessment 8-3-04, 9-30-04, 3-21-05, 5-10-05.
8. TWCC-73s from John Wyatt, D.C.
9. Narrative Reports from John Wyatt, D.C. 8-3-04, 9-30-04, 3-21-05, 5-10-05, 7-14-05.
10. Orthopedic Reports from Kenneth Berliner, M.D., 7-27-04, 12-9-04, and 3-18-05.
11. Chiropractic Modality Review, 7-30-04.
12. Chiropractic SOAP notes dated 8-3-04 through 9-27-05.
13. Muscle strength testing reports, 9-15-04 through 9-28-04 and 5-17-05 through 7-11-05.
14. Exercise Grid, 8-11-04 through 9-17-04, 9-21-04 through 9-24-04, 3-28-05 through 7-8-05.
15. Therapeutic activities and neuromuscular reeducation procedures charts and progressive resistance exercise chart, 8-11-04 through 7-13-05.
16. DD Evaluation by Walter Kane, M.D., 1-28-05.
17. Retrospective review, 6-20-05.
18. DD Evaluation by Howard Hood, M.D., 7-7-05.
19. Request for Clarification of DD report from Dr. Wyatt, 9-23-05.
20. IRO Submission Appendix A, B, C, D, E, and F; totaling 35 pages.
21. DD Evaluation by Howard Hood, M.D., 9-23-05.  
Rebuttal Report from Dr. Wyatt, 10-24-05

## CLINICAL HISTORY

According to the report from Dr. Ratliff, M.D., The Patient fractured his right hip in . He developed avascular necrosis and underwent a hemi-arthroplasty. He did extremely well and was eventually released and returned to work.

On , The Patient slipped and fell in muddy conditions while pulling some hoses and reported right hip pain and spinal complaints. The Patient was initially evaluated by Dr. Wyatt and subsequently referred to Dr. Berliner. According to the imaging, a fracture of the medial wall of the acetabulum was noted. Dr. Berliner recommended conversion of the hemi-arthroplasty to a total hip arthroplasty.

The Patient was evaluated by Dr. Ratliff on 1-16-04. He recommended a CT scan as soon as possible and he also recommended a total hip replacement.

On 4-30-04, The Patient underwent revision of Howmedica bipolar hemi-arthroplasty with 58 mm acetabulum neutral polyethylene and 32 millimeter COBOL chrome head performed by Dr. Berliner.

On 7-27-04, The Patient was re-evaluated by Dr. Berliner. The Patient reported significant pain relief following surgery. He recommended additional rehabilitation.

A chiropractic peer review was performed on 7-30-04. 12-20 sessions of chiropractic treatment were considered reasonable; however, additional treatment could not be supported.

The Patient participated in post-operative rehabilitation under the auspices of John Wyatt, D.C. from 8-3-04 through 11-15-04.

On 10-26-04, The Patient was evaluated by Dr. Ratliff. Hip flexion was 70°, extension 0°, abduction 40°, adduction 30°, internal rotation 0°, and external rotation 40°. He felt all previous treatment was reasonable and necessary; however, did not believe any additional chiropractic/physical therapy treatment was reasonable.

On 12-9-04, The Patient was re-evaluated by Dr. Berliner. X-rays demonstrated hypertrophic ossification Brooker Classification IV. ROM testing demonstrated 30 degrees flexion contracture, abduction 10°, adduction 20°, external rotation contracture of 10% and external rotation 30°. He commended excision and x-ray therapy.

On 1-18-05, The Patient was evaluated by Walter Kane, M.D. He did not believe The Patient was at maximum medical improvement.

On 3-10-05, The Patient underwent excision of the hypertrophic ossification performed by Dr. Berliner. He recommended beginning post-operative rehabilitation.

The Patient was re- evaluated by Dr. Wyatt on 3-21-05 following the removal of the hypertrophic ossification. The Patient participated in post-operative (heterotrophic ossification) rehabilitation under the auspices of Dr. Wyatt between 3-28-05 and 7-6-05.

On 6-20-05, a retrospective bill review was performed by Dr. Sato. He specifically indicated "none of the therapy appears to be directly related to the patient's surgical intervention." He did not believe the post-operative rehabilitation was reasonable or necessary.

On 7-7-05, a Designated Doctor Evaluation was performed by Howard Hood, M.D. He did not believe The Patient was at maximum medical improvement.

On 7-14-05, The Patient was re-evaluated by Dr. Wyatt. Lift tasks, strength testing and ROM testing demonstrated improvement.

On 9-23-05, a Designated Doctor Evaluation was performed by Howard Hood, M.D. Maximum medical improvement was determined on 9-21-05 and 15% WPI was assigned.

### **DISPUTED SERVICE(S)**

Under dispute is the retrospective medical necessity of 99211, 99213-25-OV, 97012-Mechanical traction, 98940, 98943-Chiropractic manipulation, 97124-Massage, 97112-Neuromuscular reeducation, 97530-Therapeutic activities, 95851-Rom, 97150-Group therapeutic procedures, 97110-therapeutic exercises, G0283-electrical stimulation, 97750-muscle testing, 99080-records, E1399-CRYO packs, 97139-EU-electrical stimulation therapy. Dates of service in dispute are 9-21-05 thru 7-6-05.

### **DETERMINATION/DECISION**

The Reviewer partially agrees with the determination of the insurance company.

1. None of the chiropractic treatment performed between 9-21-04 and 3-20-05 was reasonable or necessary.
2. The mechanical traction (97012), chiropractic manipulation (98940 and 98943), ROM testing (95851) electrical stimulation (G0283 and 97139-EU), and cryo packs (E1399) from 9-21-05 through 7-6-05 were not reasonable or necessary.
3. The evaluation and management codes (99211 and 99213-25-OV), massage (97124), neuromuscular reeducation (97112), therapeutic activities (97530), group therapeutic procedures (97150), therapeutic exercise (97110) and records/special reports (99080) were reasonable and necessary between 3-28-05 through 7-6-05.

### **RATIONALE/BASIS FOR THE DECISION**

The chiropractic treatment performed between 9-21-04 and 3-20-05 was not reasonable or necessary. The documentation clearly demonstrates improvement as a result of the post-operative treatment performed through 9-21-04; however, there is no documentation demonstrating therapeutic benefit in regards to clinically relevant outcomes as a result of the chiropractic treatment between 9-24-04 and 3-20-05.

The Reviewer believes the patient sustained an uncomplicated spinal sprain/strain injury as well as a significant hip injury as a result of the work related injury. The Reviewer believes mechanical traction (97012) and manipulation (98943) are actually contraindicated given the nature and extent of the hip injury. Furthermore, mechanical traction to the lumbar spine and spinal manipulation is not reasonable or necessary nearly one year after a lumbar sprain/strain injury.

The Reviewer believes the in-office passive treatment implemented (electrical stimulation and ice pack application) between 9-21-04 and 7-6-05 was not reasonable or necessary. There is insufficient medical evidence to support electrical stimulation in the treatment of total hip replacement. Additionally, if cryotherapy was needed on an ongoing basis, The Patient should have been given an inexpensive icepack for home application. In-office ice pack application is not reasonable or necessary.

The ROM testing (95851) was not reasonable or necessary. The chiropractor billed evaluation and management codes (99211 and 99213) on numerous sessions. These codes include range of motion measurements; therefore, billing 95851 for ROM measurements would not be reasonable.

The Reviewer believes the massage (97124) performed between 3-28-05 and 6-28-05 was reasonable and necessary. Manual procedures such as massage therapy can be beneficial in relieving symptoms and the myofascial abnormalities following the surgical interventions performed as long as the emphasis of care is on a progressive stretching/strengthening program. It is quite evident the treatment approach emphasized active care. However, the use of massage therapy (97124) should be time-limited. The Reviewer believes massage (97124) was not reasonable or necessary beyond 6-28-05.

The Reviewer believes the neuromuscular re-education, therapeutic activities, group therapeutic procedures, and therapeutic exercise performed between 3-28-05 and 7-6-05 were reasonable and necessary for two reasons. First, this treatment was performed after the heterotrophic excision surgery. Certainly, one would expect a course of post-operative rehab would be necessary. Second, the chiropractic documentation clearly demonstrates significant therapeutic benefit as a result of the active-based treatment implemented.

The Reviewer believes of the records/special reports billed (99080) and muscle testing billed (97750) were reasonable and necessary. Joint specific muscle testing and structural muscle testing is extremely important to quantify functional improvement, modify the treatment strategy, and determined the appropriate future treatment plan.

The Reviewer completely disagree with the peer review performed by Dr. Sato. This 2-page review falls below community standards. He indicated "none of the therapy appears to be directly related to the patient's surgical intervention." This statement is completely erroneous. It does not appear Dr. Sato reviewed the records. The active rehabilitation program performed by Dr. Wyatt consisted of a progressive in-office rehabilitation program directly related to the hip and associated structures such as the lumbar spine, core stabilizers, and lower extremities.

### Screening Criteria

#### 1. General:

In making his determination, the Reviewer had reviewed medically acceptable screening criteria relevant to the case, which may include but is not limited to any of the following: Evidence Based Medicine Guidelines (Helsinki, Finland); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Texas Chiropractic Association: Texas Guidelines to Quality Assurance (Austin Texas); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Mercy Center Guidelines of Quality Assurance; any and all guidelines issued by DWC or other State of Texas Agencies; standards contained in Medicare Coverage Database; ACOEM Guidelines; peer-reviewed literate and scientific studies that meet nationally recognized standards; standard references compendia; and findings; studies conducted under the auspices of federal government agencies and research institutes; the findings of any national board recognized by the National Institutes of Health; peer reviewed abstracts submitted for presentation at major medical associates meetings; any other recognized authorities and systems of evaluation that are relevant.

### CERTIFICATION BY OFFICER

IRO America has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. IRO America has made no determinations regarding benefits available under the injured employee's policy.

As an officer of IRO America Inc., I certify that there is no known conflict between the Reviewer, IRO America and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

IRO America is forwarding by facsimile, a copy of this finding to the DWC.

Sincerely,

**IRO America Inc.**



Dr. Roger Glenn Brown

**President & Chief Resolutions Officer**

## 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.

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

I hereby certify, in accordance with DWC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to DWC via facsimile, on this 28<sup>th</sup> day of November.

Name and Signature of IRO America Representative:

Sincerely,

**IRO America Inc.**



Dr. Roger Glenn Brown

**President & Chief Resolutions Officer**