



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: Integra Specialty Group, P.A. 517 north carrier Parkway Suite G Grand Prairie, Texas 75050	MDR Tracking No.: M5-06-0279-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Travelers Indemnity Company Box 05	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

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

DOCUMENTATION SUBMITTED: DWC-60 dispute package  
POSITION SUMMARY: Per the table of disputed services "Medically necessary per TWCC rules"

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

No response submitted by Respondent

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

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
05-05-05 and 06-29-05	99213 (\$68.24) and 99212 (\$48.99)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$117.23
04-26-05 to 06-29-05	97110 (\$216.84), 97032 (\$242.40) and 97140 (\$204.78)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$664.02
03-31-05 to 07-25-05	99211, 99212, 99213, 97110, 97032, 97140, 95851 and 97112 (with the exception of the codes and dates of service listed above)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00

#### 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.

Based on review of the disputed issues within the request, the Medical Review 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 10-28-05, 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.

CPT code 99080-73 dates of service 03-31-05 and 05-13-05 were denied by the carrier for medical necessity with denial code "W9". Per Rule 129.5 the TWCC-73 is a required report and not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. Reimbursement is recommended in the amount of **\$30.00 (\$15.00 X 2 DOS)**.

CPT code 99213 date of service 04-26-05 was denied by the carrier as global. Per the 2002 Medical Fee Guideline code 99213 is not global to other services billed on date of service 04-26-05. Reimbursement is recommended in the amount of **\$68.24**.

Review of CPT codes 97032 and 97140 date of service 06-22-05 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the requestor submitted convincing evidence of carrier receipt of the providers request for an EOB. Reimbursement is recommended in the amounts of **\$40.40** and **\$34.13** respectively.

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

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

**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 \$954.02. The Division finds that the requestor was not the prevailing party and is not entitled to a refund of the 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.

Ordered by:

12-27-05

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
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.**

# MEDICAL REVIEW OF TEXAS

[IRO #5259]

10817 W. Hwy. 71  
Phone: 512-288-3300

Austin, Texas 78735  
FAX: 512-288-3356

## NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	
MDR Tracking Number:	M5-06-0279-01
Name of Patient:	_____
Name of URA/Payer:	Integra Specialty Group
Name of Provider: (ER, Hospital, or Other Facility)	Integra Specialty Group
Name of Physician: (Treating or Requesting)	Darren D. Howland, DC

November 21, 2005

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on the Division of Workers' Compensation Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD  
Medical Director

cc: Division of Workers' Compensation

### CLINICAL HISTORY

Documents Reviewed Included the Following:

1. Correspondence, examination and treatment records from the provider
2. Designated doctor examination and impairment rating
3. EOBs
4. Carrier review

5. Correspondence from the carrier
6. Reports of Juan C. Yabraian, M.D.

The claimant underwent surgery and physical medicine treatments after fracturing his tibia and fibula at work on \_\_\_\_\_. An MRI performed on 05/09/05 revealed a horizontal tear of the body and posterior horn of the left medial meniscus.

#### REQUESTED SERVICE(S)

Office visits - 99211/99212/99213, therapeutic exercises - 97110, electrical stimulation - 97032, manual therapy technique - 97140, ROM measurements - 95851 and neuromuscular reeducation - 97112 from 03/31/05 through 07/25/05.

#### DECISION

The office visits on 05/05/05 and 06/29/05 are approved.

All therapeutic exercises - 97110, electrical stimulation - 97032, and manual therapy technique - 97140 from 04/26/05 through 06/29/05 are approved.

All remaining treatments, examinations and procedures are denied.

#### RATIONALE/BASIS FOR DECISION

Physical medicine is an accepted part of a rehabilitation program following injury or surgery. Based on the isometric testing performed on 05/05/05 and 06/29/05, there is adequate documentation of objective and functional improvement in this patient's condition. Therefore, the medical records fully substantiate that a portion of the disputed services during that time period fulfilled statutory requirements<sup>1</sup> for medical necessity since promotion of recovery was accomplished. However, there is no documentation to support the medical necessity for any of the treatments after 06/29/05.

Specifically in regard to the ROM testing, it was not documented as being performed in the records submitted.

Specifically in regard to the remaining 99211/99212/99213 office visits and based on CPT 2, there is no support for the medical necessity for these E/M services on each and every visit during an established treatment plan.

Specifically in regard to the neuromuscular reeducation service (97112), there was nothing in either the diagnosis or the physical examination findings on this patient that demonstrated the type of neuropathology that would necessitate the application of this service. According to a Medicare Medical Policy Bulletin 3, "This therapeutic procedure is provided to improve balance, coordination, kinesthetic sense, posture, motor skill, and proprioception. Neuromuscular reeducation may be reasonable and necessary for impairments which affect the body's neuromuscular system (e.g., poor static or dynamic sitting/standing balance, loss of gross and fine motor coordination, hypo/hypertonicity). The documentation in the medical records must clearly identify the need for these treatments." In this case, the documentation failed to fulfill these requirements, rendering the performance of this service medically unnecessary.

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<sup>1</sup> Texas Labor Code 408.021

<sup>2</sup> CPT 2004: *Physician's Current Procedural Terminology, Fourth Edition, Revised*. (American Medical Association, Chicago, IL 1999),

<sup>3</sup> HGSA Medicare Medical Policy Bulletin, Physical Therapy Rehabilitation Services, original policy effective date 04/01/1993 (Y-1B)

Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that I have no known conflicts of interest between the 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.

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.

Chief Clerk of Proceedings  
Division of Workers' Compensation  
P.O. Box 17787  
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

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

In accordance with Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 22<sup>nd</sup> day of November, 2005.

Signature of IRO Employee: \_\_\_\_\_

Printed Name of IRO Employee: Cindy Mitchell