



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.: M5-06-0320-01
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:
	Dallas Fire Insurance Company, Box 20
	Employer's Name:
	Insurance Carrier's No.:

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

Documents include the DWC-60 package. Position paper states, "Provider sent a request for reconsideration. Proof that carrier received request is also included. Carrier chose not to respond within the 28 day time frame rule."

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

Documents include the DWC-60 response. Position summary states, "Respondent asserts that, based on the Peer Review evaluation of the medical services, the charges submitted by the Requestor did not further the end of achieving effective medical care and cost control since they were 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)
10-11-04 – 3-8-05	CPT code 97110 (\$35.69 x 44 units + \$34.93 x 35 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2,792.91
10-11-04 – 3-8-05	CPT code 95851	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	0
10-11-04 – 3-8-05	CPT code 96004 (\$148.03 x 3 DOS + \$150.76 x 7 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,499.41
10-11-04 – 3-8-05	CPT code 97750-FC (\$37.25 x 10 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$372.50
10-11-04 – 3-8-05	CPT code 99213 (\$65.44 x 2 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$130.88
10-11-04 – 3-8-05	CPT code 95831	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	0
10-11-04 – 3-8-05	CPT code 97112 (\$36.79 x 13 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$478.27
10-11-04 – 3-8-05	CPT code 98940	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$32.55
10-11-04 – 3-8-05	CPT codes 97116, 97124, G0283, 97022, 97113, 97140-59	<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.

In accordance with Rule 133.308 (e) date of service 10-8-04 was untimely filed and will not be a part of this review.

CPT codes 95831 and 95851 were found by the IRO to be medically necessary. However, these are global services and are never paid separately per the 2002 MFG. Recommend no reimbursement.

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 \$5,306.52.

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 11-16-05 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 97022 on 1-5-05 was denied by the carrier as "N – not appropriately documented." The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Reimbursement of \$18.35 is recommended.

CPT code 97110 on 1-5-05 was denied by the carrier as "N – not appropriately documented." The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). The SOAP notes do clearly delineate exclusive one-on-one treatment and the requestor identified the severity of the injury to warrant exclusive one-to-one therapy. Reimbursement of \$104.79 is recommended.

CPT code 97113 on 1-5-05 was denied by the carrier as "N – not appropriately documented." The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Reimbursement of \$120.15 is recommended.

CPT code 97116 on 1-5-05 was denied by the carrier as "N – not appropriately documented." The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Reimbursement of \$61.30 is recommended.

CPT code 99082 on 1-19-05 was denied by the carrier as "U – unnecessary medical". Per Rule 134.600 travel is not handled in the Worker's Compensation Division. This service will not be a part of this review.

Regarding CPT code 99213 on 3-28-05: 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). Recommend reimbursement of \$65.44.

The work hardening program from 5-2-05 through 5-5-05 was preauthorized by the carrier. In accordance with Rule 134.600 (h) (4), the requestor provided a copy of the preauthorization letter dated 4-20-05. The carrier denied these sessions for unnecessary medical treatment based on a peer review. 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." Per Rule 134.202 (e) (5) (A) (ii) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80% of the MAR (\$51.20) Therefore in accordance with Rule 134.600 (b)(1)(B), reimbursement is recommended in the amount of \$819.20 (\$51.20 x 16 units).

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

28 Texas Administrative Code Sec. 133.307, 133.308, 134.202 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 entitled to a refund of the paid IRO fee (\$460.00). The Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute in the amount of \$6,495.75. 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 by:

1-10-06

Order by:

Margaret Ojeda

1-10-06

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.**

NOTICE OF INDEPENDENT REVIEW DECISION

December 22, 2005

Program Administrator  
Medical Review Division  
Division of Workers Compensation  
7551 Metro Center Drive, Suite 100, MS 48  
Austin, TX 78744-1609

RE: Claim #: \_\_\_\_\_  
Injured Worker: \_\_\_\_\_  
MDR Tracking #: M5-06-0320-01  
IRO Certificate #: IRO4326

TMF Health Quality Institute (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Division of Workers' Compensation (DWC) has assigned the above referenced case to TMF for independent review in accordance with DWC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and the provider, 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. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

### Clinical History

This patient sustained a work-related injury on \_\_\_ when he was using a saw to cut cement and the saw became caught in the cement and this struck him against the neck, throwing him to the pavement. A portion of the patient's treatment has included surgery as well as chiropractic care.

### Requested Service(s)

Therapeutic exercises; gait training; ROM measurements; physician review & interpretation of comprehensive computer based motion analysis, etc with written report; message therapy; electrical stimulation; functional capacity exam; office visit; application of modality to 1 or more areas-whirlpool; aquatic therapy; muscle testing extremity; neuromuscular reeducation; manual therapy technique; and chiropractic manipulative treatment provided from 10/11/2004 to 03/08/2005

### **Decision**

It is determined that the therapeutic exercises; ROM measurements; physician review & interpretation of comprehensive computer based motion analysis, etc with written report; functional capacity exam; office visit; muscle testing extremity; neuromuscular reeducation; and chiropractic manipulative treatment provided from 10/11/2004 to 03/08/2005 were medically necessary to treat this patient's condition.

It is determined that the gait training; message therapy; electrical stimulation; application of modality to 1 or more areas-whirlpool; aquatic therapy; and manual therapy technique provided from 10/11/2004 to 03/08/2005 were not medically necessary to treat this patient's condition.

### Rationale/Basis for Decision

National treatment guidelines allow for post surgical rehabilitation. There is sufficient documentation to clinically justify the ROM measurements-95851, physician review & interpretation of comprehensive computer based motion analysis, etc with written report-96004, functional capacity exam-97750-FC, office visit-99213, muscle testing extremity-95831, therapeutic exercises-97110, neuromuscular re-education-97712, and chiropractic manipulative treatment performed during the above dates of service. Diagnostic testing to evaluate and assess the outcome of treatments is medically necessary. Office visits to evaluate, document, and monitor the patient process is appropriate. Active therapy is appropriate as an integral part of a post surgical rehabilitation program.

The gait training-97116; message therapy-97124; electrical stimulation-G0283; application of modality to 1 or more areas-whirlpool-97022; aquatic therapy-97113; and manual therapy technique-97140-59 provided from 10/11/2004 to 03/08/2005 were not medically necessary to treat this patient's injury. Passive therapy utilized over one year after an injury date is not accepted within treatment guidelines. There is nothing in the documentation to justify the use of gait training for this type of injury. Aquatic therapy is not allowed for the treatment of an upper extremity and is essentially a duplication of services when performed on the same day as either therapeutic exercises or neuromuscular re-education. There is no specific data to confirm the medical necessity of message and/or manual therapy technique when used over one year after the injury date and in conjunction with active therapy.

This decision by the IRO is deemed to be a DWC decision and order.

### **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,

Gordon B. Strom, Jr., MD  
Director of Medical Assessment