



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:  Summit Rehabilitation Centers 2500 W. Freeway #200 P.O. Box 380395 Ft. Worth, TX 76102	MDR Tracking No.: M5-06-0323-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  Transcontinental Insurance Company, Box 47	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, medical documentation and CMS 1500's. Position summary states, "Provider sent a request for reconsideration. Proof that carrier received request is also included. Carrier chose not to respond with the 28 day time frame rule."

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

Documents include the DWC 60 response, Explanations of Benefits, medical documentation and CMS 1500's. No position summary was received. Position summary states, "An IRO should be assigned to resolve the medical necessity dispute before the Division rules on the fee dispute."

#### 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)
10-28-04 – 12-20-04	CPT code 97110 (\$147.96 X 29 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$4,290.84
10-28-04 – 11-24-04	CPT code 97140 (\$34.13 X 16 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$546.08
10-28-04 – 11-24-04	CPT code G0283 (\$14.41 X 16 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$230.56
10-29-04, 11-30-04, 2-17-05, 3-10-05, 5-17-05	CPT code 99213 (\$68.24 X 2 DOS + \$68.31 X 3 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$341.41
1-18-05	CPT code 97750-FC	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$296.40
10-11-04 – 5-26-05	CPT code 97012, 99213 (except as noted above), 97140 (except as noted above), G0283 (except as noted above), 96004, 97018, 95831, 99090, 95851 (3-10-05), 95832 (3-10-05)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
Grand Total			\$5,705.29

#### 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 disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$5,705.29.

CPT code 95851 and CPT code 95833 were found by the IRO to be medically necessary. However, these are global services and are never paid separately per the 2002 MFG.

In accordance with Rule 133.308 (e), requests for medical dispute resolution are considered timely if they are filed with the division no later than one year after the dates of service in dispute. The following date of service is not eligible for this review: 10-4-04.

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 10-26-05 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 97140 on 10-11-04, 12-23-04 and 1-24-05 was denied by the carrier as "G- This code is a mutually exclusive code, considered included in another code on the same day." CPT code 97140 is considered by Medicare to be a mutually exclusive procedure of CPT code 97012. Recommend no reimbursement.

CPT code 95833 on 10-22-04 was denied by the carrier as "G- This code is a mutually exclusive code, considered included in another code on the same day." CPT code 95833 is considered by Medicare to be a component procedure of CPT code 99213. The services represented by the code combination will not be paid separately. Recommend no reimbursement.

CPT code 95851 on 10-22-04 was denied by the carrier as "G- This code is a mutually exclusive code, considered included in another code on the same day." CPT code 95851 is considered by Medicare to be a component procedure of CPT code 99213. The services represented by the code combination will not be paid separately. Recommend no reimbursement.

CPT code 97750-FC on 12-21-04 (16 units) and 2-10-05 (12 units) was denied by the carrier as "G- This code is a mutually exclusive code, considered included in another code on the same day." CPT code 97750 is considered by Medicare to be a component procedure of CPT code 96004. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be considered justifiable if a modifier is used appropriately. The requestor used the modifier "FC" correctly. Recommend reimbursement of \$1,056.60.

CPT code 97012 on 10-22-04 was denied by the carrier as "F-663 – Reimbursement has been calculated according to state fee schedule guidelines." The EOB shows that these services were reimbursed to the requestor. The requestor states that no payment was received. Recommend reimbursement of \$19.21.

Regarding CPT code 99213 on 11-23-04: The EOB shows that these services were reimbursed to the requestor. The requestor states that no payment was received. Recommend reimbursement of \$68.24.

CPT code G0283 on 10-22-04 was denied by the carrier as "F-663 – Reimbursement has been calculated according to state fee schedule guidelines." The EOB shows that these services were reimbursed to the requestor. The requestor states that no payment was received. Recommend reimbursement of \$14.41.

CPT code 99080-73 on 5-25-05 was denied by the carrier as "W9-unnecessary medical treatment based on a peer review." The DWC-73 is a required report per Rule 129.5. The Requestor did submit the report which verified a change in status for the injured worker. The Medical Review Division has jurisdiction in this matter; Recommend reimbursement of \$15.00.

CPT code CPT codes 97545-WH and 97546-WH on 2-4-05 were denied by the carrier as "18-Duplicate Charge. The insurance carrier has already processed these charges." A representative of the requestor stated on 12-20-05 that this date of service had been reimbursed. No additional reimbursement recommended.

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

28 Texas Administrative Code Sec. 129.5, 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 in the amount of \$6,878.75. 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:**

Donna Auby

12-22-05

Order by:

Margaret Ojeda, Manager

12-22-05

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 of 12/12/05

November 16, 2005

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

Patient: \_\_\_\_  
DWC #: \_\_\_\_  
MDR Tracking #: M5-06-0323-01  
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

Mr. \_\_\_\_ was injured on \_\_\_\_ while employed with Gibson and Assoc. Inc. The records indicate he was injured while shoveling cement causing him to suffer lumbar pain with bilateral extremity pain. He underwent conservative care through September of 2004 when he underwent a hemilaminectomy and a discectomy at L5/S1. He began post-surgical active care on 10/22/04. He concluded post surgical rehabilitation on 12/20/04. A post rehab FCE was performed indicating the patient was at a light-medium PDL. He was referred for and approved for a Work hardening program. He was placed at MMI on 4/18/05 with a 10% rating by the designated doctor.

#### RECORDS REVIEWED

Records were received from the treating doctor/requestor and from the respondent. Records from the treating doctor/requestor include the following: 10/31/05 letter from R. Peterson, DC, CCSP, ATC, LAT, 1/25/05 work hardening approval by Concentra, 11/17/04 through 3/4/05 notes by Michael Taba, MD, TWCC 69 and report of 4/18/05 by Marco Ochoa, MD, 5/10/05 report by SIRO, lumbar MRI of 5/13/05, 11/10/04 note by Cindy Hall, 11/2/04 report by Gary Martin, DC, DACNB, Ergos Evaluation Summary of 1/18/05, SOAP notes by Marivel Subia, DC from 10/4/04 through 5/25/05, ROM exam of 11/30/04, TWCC 73 of 7/1/04, PPE of 3/10/05, 12/21/04 through 2/10/05 Physical/neurological exam sheets, 2/10/05 Ergos Eval Summary, 1/18/05 FCE, 12/21/04 Ergos Eval Summary, 12/13/04 ROM exam, 12/7/04 PPE, 11/15/04 ROM exam, 11/8/04 PPE, 11/1/04 ROM exam, 10/22/04 PPE/ROM exam and CPM group note.

The following records were received from the respondent. Records listed are noted to be different from the ones sent by the requestor/treating doctor: 11/4/05 letter by H. Douglas Pruett, cover page and pages 117-127 of TX Guidelines for chiropractic Quality Assurance and Practice Parameters 1994 and computer screen prints (pages 1-25) from Trailblazerhealth.com.

#### DISPUTED SERVICES

Disputed services include the following: 99213, G0283, 97110, 97140, 97012, 95851, 96004, 95833, 97018, 95831, 95832, 977050-FC and 99090 from 10/28/04 through 5/26/05.

#### DECISION

The reviewer disagrees with the previous adverse determination for the following codes on the following dates: **97110** (10/28/04 through 12/20/04), **97140** (10/28/04 through 11/24/04), **G0283** (10/28/04 through 11/24/04), **99213** (10/29/04, 11/30/04, 2/17/05, 3/10/05, 5/17/05), **95851** (11/1/04 through 12/13/04), **97750-FC** (01/18/05) and **95833** (11/8/04 through 12/7/04).

The reviewer agrees with the previous adverse determination for the following codes: **97012** (on all dates of service), **99213** (on any date not specifically allowed in the above paragraph), **97140** (on any date not specifically allowed in the above paragraph), **G0283** (on any date not specifically allowed in the above paragraph), **96004** (on all dates of service), **97018** (on all dates of service), **95831** (on all dates of service) and **99090** (on all dates of service), **95851** (3/10/05), and **95832** (3/10/05).

#### BASIS FOR THE DECISION

Both the requestor and the respondent have utilized the Mercy or CQAPP Guidelines in their position statements. The reviewer would like to point out that this guideline has been de-listed by the National Guideline Clearinghouse; however, since both parties have used it in support of their position, the reviewer will use it as a portion of the response. In the respondent's position letter, Mr. Pruett indicates that the CQAPP Guidelines note, "maximum exertion is increased weekly over a course of four to six weeks for the typical case". It is the reviewer's contention that a post surgical lumbar rehabilitation program is not considered the typical case. The reviewer's reading of the guidelines indicates that the typical case would be of a sprain/strain nature (grade 1 or 2) and not of a post surgical case (with excised and torn multifidus musculature yielding loss of proprioception and muscle strength/conditioning). This leads to altered functioning and altered spinal stability as per McGill, O'Sullivan and Vink.

Pg. 118 of the Guidelines indicate that MTB is reached when "failure to improve beyond a certain level of symptomatology or disability, whatever the treatment/care approach". Therapeutic necessity is defined as "exists in the presence of impairment evidence by recognized signs...likely to respond favorably to treatment planned". Furthermore, the protocols indicate on page 120 that "it is beneficial to proceed to rehabilitation phase as rapidly as possible...return to work usually be commenced at 80-90% of pre-injury status".

According to McFarland, C and Burkhart D, at least six weeks of post surgical rehabilitation are required for a proper rehabilitation program for this type of surgery. It also indicates "many times the patient will require substantially more than six weeks to be able to accomplish all steps." The current program lasted approximately eight weeks. This is certainly within the normally accepted medical protocols for the injury and is not a case of over-utilization. The ROM and strength testing showed a generally upward trend during the time in question. It appears that it stabilized or reached MTB for active therapeutics on or about 12/22/04. This does not rule out the medical necessity for the preauthorized WH program. Mr. Pruett's letter indicates that active therapy should be concluded within two months. The provider performed post surgical rehabilitation within two months of the surgeon's release to active therapy.

The reviewer finds that the passive therapies performed from 10/28/04 through 11/24/04 are medically necessary to allow the patient to perform the post surgical rehabilitation program with little or no exacerbations. This is within the month period defined by Medicare Guidelines and Mr. Pruett's letter. After this date they are not medically necessary as per the Council of Chiropractic Physiological Therapeutics and Rehabilitation Protocols. The paraffin bath was not documented in the records. Office visits are approved on a monthly basis to follow the patient through the rehabilitation protocols. The reviewer reviewed the SOAH cases quoted by the requestor and indicates that in those cases the injured employee was gaining benefit from mainly the adjustment in conjunction with an office visit; however, in this post-surgical case manipulation is not warranted. The ALJ indicates that the "some of the chiropractic services in question were medically necessary as they provided some periodic relief". This is not the case in this

matter. The claimant was likely benefiting from the properly applied active therapeutic regimen performed by Dr. Subia rather than from a 99213 office visit.

Lastly, the reviewer indicates that “guidelines” should be used as just that guidelines. Medicare guidelines were set up to treat the elderly and not an injured worker. Therefore, common sense and proper medical reasoning should be applied. The guidelines are neither set in stone, nor were they meant to be set in stone. It is the reviewers’ opinion that this provider followed through with the standard of care on the care that was approved.

The reviewer notes the 1/18/05 FCE as medically necessary as an examination during the return to work program as is standard protocol to determine the medical necessity of continuing or terminating the program. The reviewer notes the physical performance testing on 3/10/05 is not medically necessary as it is performed a full one month post-work hardening program which was last listed in the notes on 2/4/05. The 2/10/05 note indicates that the exam for an FCE is performed on this date.

#### REFERENCES

McFarland, C and Burkhart D Rehabilitation Protocols for Surgical and Nonsurgical Procedures-Lumbar Spine, 1999 North Atlantic Books. 57-62

Council of Chiropractic Physiological Therapeutics and Rehabilitation Protocols

McGill SM. Low back exercises: prescription for the health back and when recovering from injury in: ACSM resource manual: Guidelines for Exercise Testing and Prescription, 3<sup>rd</sup> Edition. Lea and Febinger.

Vink P, Van De Velde EA, Verbout. A functional subdivision of the lumbar extensor musculature. Electromyogr Clin Neurophysiol 1988;28:517-25.

O’Sullivan PB Lumbar segmental instability: clinical presentation and specific stabilizing exercise management. Man Ther 2000;5(1),2-12

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 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 12<sup>th</sup> day of December 2005**

**Signature of Specialty IRO Representative:**

**Name of Specialty IRO Representative:        Wendy Perelli**