



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: Southeast Health Services, Inc P O BOX 453062 Garland, Texas 75045	MDR Tracking No.: M5-06-0336-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: American Home Assurance Company Box 19	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: No position summary submitted by Requestor

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60
 POSITION SUMMARY: No position summary 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)
12-03-04 to 01-11-05	99211, 97140-59 and 97110	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,077.71

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 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 11-10-05, 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 97012 date of service 10-22-04 was denied by the carrier with denial code "N" (not appropriately documented). Per Rule 133.307(g)(3)(A-F) the requestor submitted documentation to support the service billed. Reimbursement is recommended in the amount of **\$19.21**.

HCPCS code A4556 date of service 10-25-04 was denied by the carrier with denial code "G" (unbundling). Per the 2002 Medical Fee Guideline HCPCS code A4556 is not global to other services billed on the date in dispute. Reimbursement is recommended in the amount of **\$15.18** per the 2004 DMEPOS Fee Schedule.

CPT code 97024 dates of service 10-27-04, 10-28-04, 11-01-04, 11-02-04, 11-04-04, 11-05-04, 11-10-04 and 11-11-04 were denied by the carrier with denial code "G" (unbundling). Per the 2002 Medical Fee Guideline code 97024 is not global to other services billed on the dates of service in dispute. Reimbursement is recommended in the amount of **\$62.08 (\$7.76 X 8 DOS)**.

CPT code 99214-25 date of service 11-11-04 was denied by the carrier with denial code "N" (not appropriately documented). Per Rule 133.307(g)(3)(A-F) the requestor submitted documentation for review that supports the service billed. Reimbursement is recommended in the amount of **\$106.36**.

CPT code 93799 date of service 12-10-04 was denied by the carrier with denial code "N" (not appropriately documented). Per Rule 133.307(g)(3)(A-F) the requestor submitted documentation to support the services billed. Reimbursement is recommended in the **\$122.00**.

CPT code 93799 date of service 01-13-05 was denied by the carrier with denial code "G" (unbundling). Per the 2002 Medical Fee Guideline code 93799 is not global to the other service billed on the date in dispute. Reimbursement is recommended in the amount of **\$122.00**.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.202(c)(1), 133.307(g)(3)(A-F) and the 2004 DMEPOS Fee Schedule

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 reimbursement in the amount of **\$1,524.54**. 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:

Authorized Signature

12-28-05

Date of Order

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:	M5-06-0336-01
Name of Patient:	
Name of URA/Payer:	Southeast Health Services, Inc.
Name of Provider: (ER, Hospital, or Other Facility)	Southeast Health Services, Inc.
Name of Physician: (Treating or Requesting)	Bryan Weddle, DC

December 19, 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. Notification of IRO Assignment, Table of Disputed Services, Carrier EOBs
2. Employer's First Report of Injury, dated
3. Medical records from Medical Center of Mesquite, dated 10/18/04
4. Treating doctor's initial consultation, dated 10/21/04
5. Thoracic spine and right elbow radiographic reports, dated 11/10/04

6. Carrier reviews by Bobby Enkvetchakul, M.D., dated 12/29/04 and 1/12/05
7. Carrier review by Phillip Osborne, M.D., dated 1/4/05
8. Carrier reviews by Brad Hayes, D.C., dated 1/11/05 and 1/30/05
9. Carrier review by Victor Roth, M.D., dated 1/18/05
10. Carrier review by Melissa Tonn, M.D., dated 10/6/05
11. Daily therapy and treatment records from the treating doctor, multiple dates
12. FCEs, dated 12/10/04, 1/13/05
13. Impairment Rating and TWCC-69, dated 1/27/05
14. Multiple TWCC-73s

Patient is a 50-year-old female deli worker who, on ____, tripped over a hose that was coming out of the floor sink and fell, striking her right elbow, right rib cage, and her right knee on the floor and the floor sink. She was treated at Mesquite Women's Medical that evening and was diagnosed with fractured right ribs. Subsequently, she presented herself to a doctor of chiropractic who initiated conservative chiropractic care, physical therapy and rehabilitation.

REQUESTED SERVICE(S)

Office visits, level I (99211), manual therapy techniques (97140), and therapeutic exercises (97110) for dates of service 12/03/04 through 01/11/05.

DECISION

Approved

RATIONALE/BASIS FOR DECISION

The five carrier reviewers opined in unison that the disputed treatments were medically unnecessary. However, these opinions appear to be in direct contrast to the findings on the two Functional Capacity Evaluations, dated on 12/10/04 and 01/13/04. In this case, those two FCEs more than adequately document objective and functional improvement in this claimant's condition. Specifically, the patient's cervical and thoracic spinal ranges of motion dramatically increased from 12/10/04 (near the initiation of the disputed treatment) to 01/13/05 (near the termination of the disputed treatment). Therefore and without question, the medical records fully substantiate that the disputed services fulfilled the statutory requirements¹ for medical necessity since promotion of recovery was accomplished and there was an enhancement of the employee's ability to return to her employment.

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

¹ Texas Labor Code 408.021

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.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell