



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 Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address: Summit Rehabilitation Centers 2500 West Freeway # 200 Fort Worth, Texas 76102	MDR Tracking No.: M5-06-0367-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Cornerstone Mutual Insurance Box 17	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION: DWC-60 dispute package POSITION SUMMARY: Necessary

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION: Response to DWC-60 POSITION SUMMARY: None 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)
11-01-04, 11-08-04, 11-15-04 and 11-17-04	96004	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
11-08-04, 11-10-04, 11-11-04 and 11-15-04	G0283	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
11-11-04	97035	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
11-29-04, 12-06-04, 12-16-04 and 01-04-05	99213	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
11-01-04 to 11-17-04	95851, 95831 and 95833 NOTE: Although services were found by the IRO reviewer to be medically necessary per the 2002 Medical Fee Guideline the services are a component procedure of code 99213 billed on the same dates of service in dispute. There are no circumstances in which a modifier would be appropriate. The services represented by the code combination will not be paid separately. 97110 (\$147.96 X 7) = \$1,035.72 97140 (\$34.13 X 7) = \$238.91 99213 (with the exceptions above) (\$68.24 X 7) = \$477.68 97750-FC (\$592.80 X 1) = \$592.80	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2,345.11

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.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 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 reimbursement in the amount of \$2,345.11. 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:

01-03-06

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.

December 15, 2005
Amended December 20, 2005
Amended December 22, 2005
Amended December 28, 2005

ATTN: Program Administrator
Texas Department of Insurance/Workers Compensation Division

7551 Metro Center Drive, Suite 100
Austin, TX 78744
Delivered by fax: 512.804.4868

Notice of Determination

MDR TRACKING NUMBER: M5-06-0367-01

RE: Independent review for ____

The independent review for the patient named above has been completed.

- Parker Healthcare Management received notification of independent review on 11.14.05.
- Faxed request for provider records made on 11.14.05.
- TDI-DWC issued an Order for payment on 11.29.05.
- The case was assigned to a reviewer on 12.5.05.
- The reviewer rendered a determination on 12.14.05.
- The Notice of Determination was sent on 12.15.05.

The findings of the independent review are as follows:

Questions for Review

The items in dispute on this report are listed as 95851 (Range of motion), 96004 (Analysis), 97110 (Therapeutic Exercise), 97140 (Manual Therapy Technique), 99213 (Office Visit), 95831 and 95833 (Muscle Testing), G0823 (Electrical Stimulation), 97035 (Ultrasound), 97750-FC (FCE). All were denied due to medical necessity. The dates of service in question are listed as 11.1.04 through the date of 1.4.05.

Determination

PHMO, Inc. has performed an independent review of the proposed care to determine if the adverse determination was appropriate. After review of all medical records received from both parties involved, the PHMO, Inc. physician reviewer has determined to **overturn the denial** on the disputed service(s) that occurred from 11.1.04-11.17.04 to include only CPT codes: 97750-FC (FCE), 95851 (Range of motion), 97110 (Therapeutic Exercise), 97140 (Manual Therapy Technique), 99213 (Office Visit), 95831 and 95833 (Muscle Testing).

The PHMO, Inc. physician reviewer has determined to **uphold the denial** on all of the disputed CPT codes G0823 (Electrical Stimulation), 97035 (Ultrasound) and the code 96004 (Analysis).

It is also determined to **uphold the denial** on all of the disputed CPT codes that occurred on or after 11.29.04.

Summary of Clinical History

The claimant was injured as a result of a work related injury on _____. He was driving a company car and the right tire blew out and the car flipped twice. As a result, he started to have pain in his right shoulder and neck. He had shoulder surgery on 8.23.04. He started to have post surgical care on 9.7.04, which the care was apparently considered necessary until 11.1.04. At that point, the care was no longer considered necessary and thus denied. This gave the patient approximately 8 weeks of care before necessity was considered unsupportable.

Clinical Rationale

There is excellent documentation demonstrating that the services rendered were objectively beneficial for the patient until 11.17.04. The documentation demonstrated objective improvement with outcome assessment until that date, after that time period there was little to no documentation to support ongoing care.

Thus, the care including FCE, range of motion studies, therapeutic exercise, manual therapy technique, office visits and muscle testing should be considered medically necessary up until the date of 11.17.04. The passive modalities administered were well outside of the acute and sub-acute time frame of recovery thus not necessary and likely ineffective. Analysis of all reports should not be billed, it is understood that all testing has to have an analysis in order for it to be useful and should be included as part of the service itself, not billed separately.

Clinical Criteria, Utilization Guidelines or other material referenced

- *Occupational Medicine Practice Guidelines*, Second Edition.
 - *The Medical Disability Advisor*, Presley Reed MD
 - *A Doctors Guide to Record Keeping*, Utilization Management and Review, Gregg Fisher
-

The reviewer for this case is a doctor of chiropractic peer matched with the provider that rendered the care in dispute. The reviewer is engaged in the practice of chiropractic on a full-time basis.

The review was performed in accordance with Texas Insurance Code 21.58C and the rules of Texas Department of Insurance /Division of Workers' Compensation. In accordance with the act and the rules, the review is listed on the DWC's list of approved providers or has a temporary exemption. The review includes the determination and the clinical rationale to support the determination. Specific utilization review criteria or other treatment guidelines used in this review are referenced.

The reviewer signed a certification attesting that no known conflicts-of-interest exist between the reviewer and the treating and/or referring 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.

The reviewer also attests that the review was performed without any bias for or against the patient, carrier, or other parties associated with this case.

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 address for the Chief Clerk of Proceedings would be: P.O. Box 17787, Austin, Texas, 78744.

I hereby verify that a copy of this Findings and Decision was faxed to Texas Department of Insurance /Division of Workers Compensation applicable to Commission Rule 102.5 this 15th day of December, 2005. This determination was amended this 28th day of December, 2005. The Division of Workers Compensation will forward the determination to all parties involved in the case including the requestor, respondent and the injured worker.

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.