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: Summit Rehabilitation Centers 2500 W. Freeway #200 Ft. Worth, TX 76102	MDR Tracking No.: M5-06-0375-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Liberty Mutual Fire Insurance, Box 28	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, medical documentation, Explanations of Benefits and CMS 1500's. Position summary states, "All services are necessary to treat the injured worker."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No Position Summary received.

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)
10-13-04 – 6-29-05	CPT code 95833	☒ Yes ☐ No	0
10-13-04 – 6-29-05	CPT code 95851	☒ Yes ☐ No	0
10-13-04 – 6-29-05	CPT code 96004 (1 DOS X $152.75 + 2 DOS X $155.25)	☒ Yes ☐ No	$773.75
10-13-04 – 6-29-05	CPT code 99213 (22 DOS X $68.31)	☒ Yes ☐ No	$1502.82
10-13-04 – 6-29-05	CPT code 97110 (92 units X $36.14)	☒ Yes ☐ No	$3324.88
10-13-04 – 6-29-05	CPT codes G0283, 97012, 97140	☐ Yes ☒ 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.

CPT codes 95833 and 95851 for 10-13-04 – 6-29-05 were found to be medically necessary. However, per the 2002 MFG, these codes are "component procedures of CPT code 99213. The services represented by the code combination will not be paid separately." 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 $5601.45.

CPT code 99080-73 date of service 03-10-05 was denied with denial code "U" for unnecessary medical treatment. The IRO reviewer concluded that the office visit (99213) on date of service 03-10-05 was medically necessary. Based on Rule 133.308(p)(5) An IRO decision is deemed to be a commission decision and order, therefore reimbursement is recommended for this report also. Recommend reimbursement of $15.00

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 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 additional reimbursement in the amount of $5,616.45. 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:

	Donna Auby	1-4-06
Order by:		
	Margaret Ojeda, Manager	1-3-06
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.

December 21, 2005

TDI, Division of Workers' Compensation
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-06-0375-01
DWC#:
Injured Employee: ___
DOI: ___
IRO Certificate No.: IRO 5055

Dear Ms. ___:

IRI has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc. and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him 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 Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic, and is currently on the DWC Approved Doctor List.

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,

Gilbert Prud'homme
General Counsel
GP:dd

REVIEWER'S REPORT
M5-06-0375-01

Information Provided for Review:
DWC-60, Table of Disputed Services, EOB's
Information provided by Requestor:
- Correspondence
- PT Notes 10/13/04 – 06/29/05
- Range of Motion Tests 10/13/04 – 03/10/05
- Radiology 09/25/04

Information provided by Respondent:
- Designated Reviews

Pain Management:
- Office Notes 05/03/05 – 06/21/05

Orthopedics:
- Office Visit 12/15/04

Clinical History:
Records indicate the patient was injured while performing his usual duties as a groundskeeper on ___. He was picking up trashbags and felt a sudden onset of pain. He was seen by the company doctor but continued to have ongoing problems, which necessitated changing treatment to another doctor on 10/11/05. On 09/25/04, the patient received a lumbar spine MRI scan, which revealed significant problems. By designated doctor on 02/14/05, the claimant was found not be at maximum medical improvement. He continued to have treatment, which included injection therapy, and was found on 09/16/05 to be at MMI with effective date 08/16/05 with a 10% impairment rating.

Disputed Services:
95833 muscle test, 95851 ROM, 96004 physician review of motion test, 99213 office visit, G0283 electrical stimulation, 97012 mechanical traction, 97110 therapeutic exercises, and 97140 manual therapy.

Decision:
The reviewer partially agrees with the determination of the insurance carrier in this case.

Rationale:
The records indicate the patient was initially injured and received appropriate treatment. Over the course of treatment, he was seen by other specialists as well as had appropriate diagnostic testing. In conjunction with chiropractic care and rehabilitation, he also received injection therapy. There is sufficient documentation and medical necessities for this patient to receive 95833 muscle test, 95851 ROM, 96004 physician review of motion test, 99213 office visit, and 97110 therapeutic exercises during the period of 10/13/04 through 06/29/05. However, there is no justification for the passive therapy of G0283 electrical stimulation, 97012 mechanical traction, or 97140 manual therapy during that same period of time. National treatment guidelines do allow for active therapy to be utilized in conjunction with injection therapy, as was done in this case.