



## MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

### Retrospective Medical Necessity

#### 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 Ft. Worth, TX 76102	MDR Tracking No.: M5-06-0417-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  Dallas Fire Insurance Company, Box 20	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

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

Documents include DWC-60 package. Position Summary 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 DWC-60 response. Position paper states, "The claimant asserts that no EOB's were provided for the following dates; 10-20-04 – 10-21-04. However, the EOB's attached herewith reflect fee reductions pursuant to the State Guidelines."

#### 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)
11-19-04, 12-13-04, 12-14-04, 12-15-04, 1-3-05, 1-11-05, 1-19-05, 1-24-05	CPT code 99213 (\$68.24 X 4 DOS + \$68.31 X 4 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$546.20
10-25-04 – 1-24-05	CPT code 97012 + (\$19.21 X 38 units + \$19.01 X 1 unit)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$748.99
1-03-05	CPT code 99354	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$127.49
1-05-05	CPT code 96004	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$155.25
1-05-05	CPT code 97750-FC (\$38.65 X 16 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$618.40
10-25-04 – 1-24-05	CPT code 97140-59 (\$34.13 X 28 DOS + \$34.16 X 1 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$989.80
10-25-04 – 1-24-05	CPT code 98940 (\$33.61 X 26 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$873.86
10-25-04 – 1-24-05	CPT code 99080-73 (\$15.00 X 3 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$45.00
10-25-04 – 1-24-05	CPT code 99373	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$32.00
10-25-04 – 11-17-04 11-23-04 – 12-8-04 12-23-04, dates from 10-25-04 – 1-24-05 not listed above	CPT code 99213	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
1-27-05 – 6-8-05	CPT codes 97012, 97140, 97140-59, 98940, 99213, 99373, 99354, 96004, 97750-FC, 95851, 95833, 97110	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0

10-25-04- 6-8-05	G0283	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
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**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.

Dates of service 10-19-04 – 10-22-04 were untimely filed and will not be a part of this review per Rule 133.308 (e).

The Division has reviewed the enclosed IRO decision and determined that the requestor did not prevail on the majority of the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$4,136.99.

Regarding CPT code 99082 on 11-11-04: Travel expenses are not handled in MDR per Rule 134.600.

In accordance with Rule 134.600 (h) (4), the requestor provided a copy of the preauthorization letter dated 1-20-05 for two weeks of a work hardening program. This service was rendered from 1-27-05 – 2-9-05. The carrier denied these sessions for unnecessary medical treatment. 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." The insurance carrier will be billed for this violation of the rules. Reimbursement is recommended in accordance with Rules 134.600 and 134.202 (e) (5) (A) (ii). Recommend reimbursement of \$3,276.80.

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

28 Texas Administrative Code Sec. 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 not entitled to a refund of the paid IRO fee. The Division has determined that the requestor is entitled to reimbursement in the amount of \$7,413.79. 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

1-27-06

Order by:

Amy Rich

1-27-06

Authorized Signature

Typed Name

Date of Findings and Decision

**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.

January 19, 2006

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

Patient: \_\_\_\_  
DWC #: \_\_\_\_  
MDR Tracking #: M5-06-0417-01  
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI-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

According to the records received and reviewed, Mr. \_\_\_\_ was working for AMS Staff Leasing when he was injured in a work related accident on \_\_\_\_\_. The records reflect that on \_\_\_\_\_, Mr. \_\_\_\_ was folding and lifting boxes when he felt pain in his low back and in the right side of his neck. The pain radiated to the right shoulder and down the right lower extremity. Mr. \_\_\_\_ also reported a burning and tingling into the right lower extremity. The patient initially presented to Concentra for treatment and later changed treating doctors to Summit Rehab Centers on or about 10-19-2004. At that point, Summit Rehab Centers initiated a treatment plan. Mr. \_\_\_\_ underwent conservative care and therapy and later received ESI's and also underwent a work hardening program. An MRI of the patient revealed a 2-3mm disc bulge at L4-L5.

RECORDS REVIEWED

Numerous treatment notes, diagnostic tests, evaluations, and other documentation were reviewed. Records included but were not limited to the following:

Medical Dispute Resolution paperwork  
Numerous EOB's  
Multiple TWCC forms  
Position Statement from Dr. Petersen  
Review from IMO

Records from Dr. Sedighi  
Reports from Dr. Stanton recommending and performing ESI's 8-2004  
Lumbar MRI from Advanced Medical Imaging 7-15-2004  
Cervical MRI from Advanced Medical Imaging 7-15-2004  
Reports from Dr. Small  
Reports from Dr. Eaton  
Records from Concentra  
Records from Atlantis Healthcare/Dallas Rehab  
Records from Dr. Subia  
Position Letter from Lewis & Blackhaus  
Report from Dr. Bauer  
DD Report by Dr. Seltzer Report performed on 9-14-2005 assigning MMI at 0% on 9-12-2004

#### DISPUTED SERVICES

The items in dispute are the retrospective medical necessity of Mechanical Traction 97012, Manual Therapy 97140(59), Chiropractic Manipulation 98940, Office Visit 99213, Electrical Stimulation G0283, Phone Call 99373, Prolonged Physician Service 99354, Physician Review 96004, Functional Capacity Evaluation 97750, Range of Motion 95851, Manual Muscle Testing 95833 and Therapeutic Exercises 97110 from 10-25-2004 to 6/8/2005.

#### DECISION

The reviewer agrees with the previous adverse determination regarding all services from 1-27-2005 through 6-8-2005.

The reviewer agrees with the previous adverse determination regarding 99213 for dates of service 10-25-2004 through 11-17-2004 and 11-23-2004 through 12-8-2004 and 12-23-2004. The reviewer disagrees with the remaining 99213 from 10-25-2004 through 1-24-2005.

The reviewer agrees with the previous adverse determination regarding G0283 for all dates of service under review.

The reviewer disagrees with the previous adverse determination regarding the remaining services between 10-25-2004 through 1-24-2005.

#### BASIS FOR THE DECISION

The basis for the determination is based upon the Medical Disability Advisor, the Official Disability Guidelines, and Evidence Based Medicine Guidelines. The Medicare guidelines and payment policies were also utilized in the decision making process of this review. The AMA CPT Code Book was also utilized in this determination. In regards to the office visits, there is insufficient documentation or clinical rationale as to why office visits 99213 would need to be performed in addition to 98940 on the same visit. The passive modalities G0283 utilized exceed the usual and customary time frames for providing passive care. Given the fact that the patient underwent invasive procedures such as ESI's and the patient had multiple body parts injured, the normal healing time could be extended.

The MDA gives approximately 3 months for the duration of length of disability for this type of injury as identified below:

**Lumbar Sprain/Strain**

Duration in days			
Job Classification	Minimum	Optimum	Maximum
Sedentary	1	3	7
Light	1	7	14
Medium	3	14	28
Heavy	7	21	42
Very Heavy	7	28	56

**Lumbar Disc Injury Medical treatment.**

Duration in Days			
Job Classification	Minimum	Optimum	Maximum
Sedentary	1	7	14
Light	1	14	21
Medium	1	21	42
Heavy	1	56	91
Very Heavy	1	91	168

Given the fact that the patient underwent invasive procedures such as ESI's and the patient had multiple body parts injured, the normal healing time could be somewhat extended. Also since the patient changed treating doctors in October and the new treating doctor specifically states that he was unable to attain prior records, it can be assumed that the treating doctor initiated a new treatment plan in October and thus approximately 3 months of care would be clinically warranted if appropriately administered and documented. It should also be noted that the patient's FCE performed on 2-15-2005 actually shows a worsening of some of the patient's functional abilities and thus the continuation of the same type of care past that point would not be clinically necessary.

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 DWC- Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the Division via facsimile, U.S. Postal Service or both on this 19<sup>th</sup> day of January 2006**

**Signature of Specialty IRO Representative:**

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