



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: Humpal Physical Therapy 5026 Deepwood Circle Corpus Christi, Texas 78415	MDR Tracking No.: M5-06-0428-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Insurance Company Box 54	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: Per the table of disputed services "treatment is related to injury"

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60
POSITION SUMMARY: "Therefore, Texas Mutual requests that the request for dispute resolution filed by HUMPAL PHYSICAL THERAPY PC, be conducted under the provisions of the APA set out above".

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
04-01-05 to 06-28-05	97140, 97110, 97112, 97035, 97004 and 97032	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00

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 **not** prevail on the disputed medical necessity issues.

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 11-22-05, 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 97110 (1 unit) date of service 06-21-05 was denied by the carrier with denial code "97/286"
(payment is included in the allowance for another service/procedure/additional visit fees are warranted only when other significant identifiable services are rendered in conjunction with casting). Per the 2002 Medical Fee Guideline code 97110 is not global to other services billed on date of service 06-21-05. Per Rule 133.307(g)(3)(A-F) the requestor submitted documentation, however, the documentation does not support the services billed. Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one". Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light of all of the Division requirements for proper documentation. No reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 133.307(g)(3)(A-F)

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 reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

12-28-05

Authorized Signature

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.

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:	M5-06-0428-01
Name of Patient:	
Name of URA/Payer:	Humpal Physical Therapy
Name of Provider: (ER, Hospital, or Other Facility)	Humpal Physical Therapy
Name of Physician: (Treating or Requesting)	Jon Blackburn, OTR

December 22, 2005

An independent review of the above-referenced case has been completed by a medical physician board certified in physical medicine and rehabilitation. 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

Records Reviewed

- A. Billing documents
- B. Request for reconsideration
- C. Internal Peer Review of Russell Hanks, P.T.
- D. Letter of Medical Necessity
- E. Physical therapy notes
- F. Radiology reports
- G. Neurology assessment
- H. EMG Report

This is a 41-year-old gentleman who reportedly slipped and fell sustaining a shoulder dislocation. An avulsion of the humeral head was noted and surgical intervention completed. The neurologic examination noted no focal muscle atrophies as being identified. Some upper extremity weakness was noted. Multifocal denervations were identified on EMG. Dr. Guido suggested continuous aggressive therapy.

REQUESTED SERVICE(S)

Manual Therapy; Therapeutic Exercise; Neuromuscular re-education; Ultrasound; OT re-evaluation; Electrical stimulation for dates of service 4/1/05 through 6/28/05.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

AS noted in the ODG, there are specific guidelines. Additionally as reported in Krusen's text of Physical Medicine and Rehabilitation there is a limitation to therapeutic intervention and that is related to objectification of improvement. There is no value in repeating modalities when there is no documented improvement. Joint mobilization after a shoulder subluxation when there was a nearly full range of motion is not supportive of the additional passive modalities. Further neuromuscular re-education is designed for those with significant neurologic lesions that require rehabilitation. In this case there was no significant loss of range of motion or functionality.

Repeating these maneuvers when the rehabilitation is reached could only be described as excessive. As noted in the Philadelphia Panel Study, the use of electrical stimulus after the acute phase has little if any efficacy. Moreover, as noted in a recent edition of the Journal Spine, (11/1) the efficacy of such devices is no better than placebo in mechanical neck pain.

While noting the citations offered by the therapist, the reality is that there is no objectification of improvement after an extra-ordinary amount of therapy services and the lack of improvement is no reason to repeat a failed regimen.

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 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