



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: Puig Physical Therapy 2122 E. Griffin Parkway Mission, Texas 78572	MDR Tracking No.: M5-06-0495-01
	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: DWC-60 dispute package
POSITION SUMMARY: Per the table of disputed services "was denied".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION: Response to DWC-60 dispute
POSITION SUMMARY: "Therefore, Texas Mutual requests that the request for dispute resolution filed by PUIG PHYSICAL THERAPY CENTER, 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)
03-07-05 to 04-20-05	97110 (3 units for each DOS reviewed) (\$33.56 X 38 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,275.28
03-07-05 to 04-20-05	G0283, 95851, 95831, 97140, 97010	<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 **prevailed** on the **majority** of 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 01-03-06, 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 97010 date of service 04-20-05 denied with denial code "97" (payment is included in the allowance for another service/procedure). 97010 is a bundled service code and considered an integral part of a therapeutic procedure(s). Per the 2002 Medical Fee Guideline no reimbursement is recommended.

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 additional reimbursement in the amount of \$1,275.28.

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 \$650.00. 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:

01-18-06

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.



Specialty Independent Review Organization, Inc.

December 29, 2005

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

Patient: ____
DWC #: ____
MDR Tracking #: M5-06-0495-01
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

The records that were received and reviewed indicated that ____ was injured in a work related accident on _____. Mr. ____ was working for _____ when he sustained an injury to the right shoulder after lifting a case of liquids. An MRI of the right shoulder revealed tendinosis of the supraspinatus muscle with no tear. The patient saw Dr. Owen on 10-28-2004 and was placed on medications and received a subacromial injection. The patient was also placed on restrictions at that time. The patient underwent non-operative, conservative care for approximately two months and then proceeded to surgery for the right shoulder. On 12-22-2004, the patient underwent arthroscopic repair to the right shoulder. The patient was referred back to therapy for post-operative rehabilitation. The patient was released to unrestricted duty on 3-28-2005.

RECORDS REVIEWED

Medical Dispute Resolution paperwork
Numerous EOB's
Multiple HCFA's
Letter from Texas Mutual
MRI Right Shoulder from Open MRI
Records from Kip Owen MD
Records from Doctors Hospital at Renaissance
Records from PUIG
Request for Reconsideration from PUIG

DISPUTED SERVICES

The items in dispute are the retrospective medical necessity of 97110-therapeutic exercises, G0283-electrical stimulation, 95851-ROM, 95831-muscle testing, 97140-manual therapy and 97010-hot/cold pack from 3-7-05 through 4-20-05.

DECISION

The reviewer disagrees with the previous adverse determination regarding 97110 therapeutic exercises for up to three units for the dates under review. In other words, up to three units of 97110 for each date of service under review should be approved.

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

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. Medicare payment policies state, "for all PM&R modalities and therapeutic procedures on a given day, it is usually not medically necessary to have more than one treatment session per discipline. Depending on the severity of the patient's condition, the usual treatment session provided in the home or office setting is 30 to 45 minutes. The medical necessity of services for an unusual length of time must be documented." The documentation does not support the continued need of passive therapies or manual treatment measures for the dates of service under review. The MDA gives approximately 3 months for the duration of length of disability for this type of injury and the therapeutic exercises would be appropriate given the patient's PDL classification. Clinical Orthopaedic Rehabilitation 2nd edition also states that 16 weeks of post-surgical rehabilitation would be appropriate. In regards to the range of motion testing and muscle testing of the patient, there is no documented change in the treatment plan after the testing and no rationale given for performing these services and thus clinical necessity is not established.

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 via facsimile, U.S. Postal Service or both on this 29th day of December 2005

Signature of Specialty IRO Representative:

Name of Specialty IRO Representative: Wendy Perelli