



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.: M5-06-0631-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Liberty Insurance Corporation, 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 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 the DWC 60 response. Position summary states, "We base our payments on the Texas Fee Guidelines and the Texas Workers' Compensation Commission Acts and Rules."

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)
2-24-05 – 7-8-05	CPT code 95831	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$35.23
2-24-05 – 7-8-05	CPT code 95833 (see note below)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	0
2-24-05 – 7-8-05	CPT code 95851 (see note below)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	0
2-24-05 – 7-8-05	CPT code 97110 (\$34.93 X 50 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,746.50
2-24-05 – 7-8-05	CPT code 96004 (\$150.76 X 4 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$603.04
2-24-05 – 7-8-05	CPT code 97124 (\$27.81 X 3 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$83.43
2-24-05 – 7-8-05	CPT code 99080-73	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$15.00
2-24-05 – 7-8-05	CPT code 99213 (\$65.44 X 15 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$981.60
2-24-05 – 7-8-05	CPT code 97140 (\$33.04 X 9 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$297.36
2-24-05 – 7-8-05	CPT code 97750-FC	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$596.00
2-24-05 – 7-8-05	CPT code 97116	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
	Grand total		\$4,358.16

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 were both found to be medically necessary by the IRO. However, these codes are considered by Medicare to be a component procedure of CPT code 99213. There are no circumstances in which a modifier would be appropriate. The services represented by the code combination will not be paid separately.

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 \$4,358.16.

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 1-2-06 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.

HCPCS code A4556 on 2-24-05 was denied by the carrier as "615-incidental to primary code." Per the 2002 MFG this code is a bundled/exclusive procedure. This service will not be paid separately.

CPT code 97140 on 3-1-05 was denied by the carrier as "687-mutually exclusive to another on this date of service." This code is considered by Medicare to be a component procedure of CPT code 98940 which was billed on this date of service. There are no circumstances in which a modifier would be appropriate. The services represented by the code combination will not be paid separately.

CPT codes 95831 and 95833 on 3-7-05-05 were denied by the carrier as "693-incidental to related primary code." These codes are considered by Medicare to be a component procedure of CPT code 99213 which was billed on this date of service. There are no circumstances in which a modifier would be appropriate. The services represented by the code combination will not be paid separately.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and Rule 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 reimbursement in the amount of \$4,358.16. 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 and Order by:

Authorized Signature

Donna Auby

Typed Name

2-23-06

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.



PROFESSIONAL ASSOCIATES

NOTICE OF INDEPENDENT REVIEW

NAME OF PATIENT: _____
IRO CASE NUMBER: M5-06-0631-01
NAME OF REQUESTOR: Summit Rehabilitation Centers
NAME OF PROVIDER: Luz D. Gonzalez, D.C.
REVIEWED BY: Licensed by the Texas State Board of Chiropractic Examiners
IRO CERTIFICATION NO: IRO 5288
DATE OF REPORT: 02/08/06

Dear Summit Rehabilitation Centers:

Professional Associates has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO) (#IRO5288). Texas Insurance Code Article 21.58C, effective September 1, 1997, allows a patient, in the event of a life-threatening condition or after having completed the utilization review agent's internal process, to appeal an adverse determination by requesting an independent review by an IRO.

In accordance with the requirement for TDI-Division of Workers' Compensation (DWC) to randomly assign cases to IROs, DWC has assigned your case to Professional Associates for an independent review. The reviewing physician selected has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, the reviewing physician reviewed relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal. determination, and any documentation and written information submitted in support of the appeal.

This case was reviewed by a physician reviewer who is Licensed in the area of Chiropractics and is currently listed on the DWC Approved Doctor List.

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

REVIEWER REPORT

Information Provided for Review:

Chiropractic treatment with Luz Gonzalez, D.C. dated 02/24/05, 02/28/05, 03/01/05, 03/02/05, 03/03/05, 03/04/05, 03/07/05, 03/08/05, 05/04/05, 05/31/05, 06/01/05, 06/03/05, 06/07/05, 06/08/05, 06/10/05, 06/14/05, 06/15/05, 06/17/05, 06/21/05, 06/22/05, 06/24/05, 06/30/05, 07/01/05, 07/05/05, 07/06/05, and 07/08/05

An MRI of the right shoulder interpreted by Phyllis Frostenson, M.D. dated 03/14/05

Evaluations with Frank H. Swords, D.O. dated 03/24/05, 05/26/05, and 06/27/05

An operative report from Dr. Swords dated 04/19/05

A Functional Capacity Evaluation (FCE) with Dr. Gonzalez dated 08/18/05
A letter written by R. Todd Petersen, D.C. dated 01/16/06

Clinical History Summarized:

Chiropractic treatment was performed with Dr. Gonzalez from 02/24/05 through 07/08/05 for a total of 26 sessions. An MRI of the right shoulder interpreted by Dr. Frostenson on 03/14/05 revealed a type II acromion in the AC joint with impingement, diffuse tendinosis with a small suspected partial rotator cuff tear, and a minimal ligamentous sprain of the coracohumeral ligament. On 03/24/05, Dr. Swords recommended a right shoulder injection, physical therapy, and Bextra samples. Dr. Swords performed right shoulder arthroscopy, a Neer acromioplasty, and a distal clavicle excision on 04/19/05. On 05/26/05, Dr. Swords performed a right shoulder injection. On 08/18/05, Dr. Gonzalez noted the patient finished a work hardening program and was able to function in the heavy physical demand level, according to an FCE. On 01/16/06, Dr. Petersen wrote a note stating treatment from 02/24/05 through 07/08/05 was reasonable and necessary.

Disputed Services:

Muscle testing-extremity, muscle testing-whole body, ROM measurements, therapeutic exercises, gait training, massage therapy, special report office visits, manual therapy technique, Functional Capacity Evaluation (FCE), and physician review and interpretation of comprehensive based motion analysis with written report from 02/24/05 through 07/08/05

Decision:

I partially agree with the requestor. The muscle testing-extremity, muscle testing-whole body, ROM measurements, therapeutic exercises, massage therapy, special report, office visits, manual therapy technique, FCE, and physician review and interpretation of comprehensive based motion analysis with written report from 02/24/05 through 07/08/05 were medically necessary. However, the gait training from 02/24/05 through 07/08/05 was neither reasonable nor medically necessary.

Rationale/Basis for Decision:

According to the records reviewed, the patient was injured on _____. The patient received treatment from 02/24/05 through 07/08/05. The patient received conservative treatment to the thoracic spine, cervical spine, and right shoulder from 02/24/05 through 03/08/05. According to the Official Disability Guidelines (ODG) for shoulder injuries and the North American Spine Society's Multidisciplinary Guidelines for Spine Care Specialists both allow up to eight weeks for initial treatment for the acute injury. The treatments and testing from 02/24/05 to 03/08/05 were within treatment parameters set by the previously stated guidelines. The patient had surgery to the right shoulder on 04/19/05 and was released to begin postoperative rehabilitation on 05/26/05. According to the ODG, 2005, postoperative treatment for the arthroscopic surgery to the shoulder can last up to eight weeks. The treatment dates from 05/31/05 (the first day the patient was seen for postoperative rehabilitation) to 07/08/05 fall within the accepted parameters of the previously stated guidelines for postoperative care for the shoulder. In addition, the baseline shoulder measurements taken on 05/04/05 was necessary to obtain a starting baseline for range of motion in the right shoulder to be compared to later in the patient's treatment. The only treatment that was not found to be medically necessary was the gait training provided from 02/24/05 through 07/08/05. There was no evidence in the medical records reviewed that showed the patient had any gait, balance, or weightbearing problems that required gait training.

In summary, the muscle testing-extremity, muscle testing-whole body, ROM measurements, therapeutic exercises, massage therapy, special report, office visits, manual therapy technique, FCE, and physician review and interpretation of comprehensive based motion analysis with written report from 02/24/05 through 07/08/05 were medically necessary to treat this patient, except for the gait training during that same period, which would not be medically necessary.

The rationale for the opinions stated in this report are based on clinical experience and standards of care in the area as well as broadly accepted literature which includes numerous textbooks, professional journals, nationally recognized treatment guidelines and peer consensus.

This review was conducted on the basis of medical and administrative records provided with the assumption that the material is true and correct.

This decision by the reviewing physician consulting for Professional Associates is deemed to be a Division decision and order.

YOUR RIGHT TO REQUEST A HEARING

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. A request for a hearing should be faxed to 512-804-4011 or sent to:

Chief Clerk of Proceedings/Appeals Clerk
TDI-Division of Workers' Compensation
P. O. Box 17787
Austin, TX 78744

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization's decision was sent to DWC via facsimile or U.S. Postal Service on 02/08/06 from the office of Professional Associates.

Sincerely,

Lisa Christian
Secretary/General Counsel