



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

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier

Requestor's Name and Address:

Summit Rehabilitation Centers
2500 West Freeway #200
Fort Worth TX 76102

MDR Tracking No.: M5-06-0683-01

Claim No.:

Injured Worker's Name:

Respondent's Name and Address:

Hartford Underwriters Insurance Box 27

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DWC-60 package. Position Summary: Services necessary.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Carrier did not respond to DWC-60 package.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
1-19-05 to 7-15-05	99213 21 days x \$65.44 = \$1,374.24 95851 and 95831 No reimbursement. See Note below	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,374.24
1-19-05 to 7-15-05	96004 3 days x \$150.76 = \$452.28 97110 39 units x \$34.93 = \$1,362.27 G0283 2 units x \$14.16 = \$28.32 97116 10 units x \$30.65 = \$306.50 97140 5 units x \$33.04 = \$165.20 97124 4 units x \$27.81 = \$111.24	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2,425.81
5-20-05	97750-FC 9 units x \$37.25 = \$335.25	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$335.25
	TOTAL		\$4,135.30

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 disputed medical necessity issues.

Codes 95851 billed on 3-15-05 and 95831 billed on 5-6-05 were reviewed by the IRO and deemed to be medically necessary; however, Per the 2002 Medical Fee Guidelines these two are included with an office visit. Office visit 99213 was billed on both dates of service. No modifiers are allowed and reimbursement is included with the office visit billed. Therefore, no additional reimbursement can be recommended.

Based on review of the disputed issues within the request, Medical Review 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 12-28-05, Medical Review submitted a Notice to the 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.

Codes 97110, 97116, 97140, 99213 billed on 3-28-05 were denied as "A, preauthorization required but not requested." Per the 2002 Medical Fee Guideline and Rule 134.600 (h), office visits and physical therapy do not require preauthorization. The carrier inappropriately denied these services on this date. A C&P referral may be made. Since all these services were deemed medically necessary by the IRO as stated above, recommend additional reimbursement of \$34.93 + \$30.65 + \$33.04 + \$65.44 = \$164.06.

Codes 95831 billed on 3-31-05 and 95851 billed on 4-12-05 were denied as "F, included in a more comprehensive code which accurately describes the procedure performed." Office visit 99213 was billed on both dates of service. Per the 2002 Medical Fee Guidelines, these two codes are included with an office visit. No modifiers are allowed and reimbursement is included with the office visit billed. Therefore, no additional reimbursement can be recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.202

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 \$4,299.36. 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 \$460.00. 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:

Medical Dispute Officer

1-31-06

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.

P-IRO

An Independent Review Organization
7626 Parkview Circle
Austin, Texas 78731

Phone: 512-346-5040
Fax: 512-692-2924

January 24, 2006

TDI-DWC Medical Dispute Resolution
Fax: (512) 804-4868

Delivered via Fax

Patient / Injured Employee _____
TDI-DWC # _____
MDR Tracking #: M5-06-0683-01
IRO #: 5312

P-IRO, Inc. has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI-Division of Worker's Compensation (DWC) has assigned this case to P-IRO for independent review in accordance with DWC Rule 133.308 which allows for medical dispute resolution by an IRO.

P-IRO has performed an independent review of the proposed care 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.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Provider board certified and specialized in Chiropractic Care. The reviewer is on the DWC Approved Doctor List (ADL). The P-IRO Panel Member/Reviewer is a health care professional who has signed a certification statement stating that no known conflicts of interest exist between the Reviewer 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 carriers health care providers who reviewed the case for decision before referral to IRO America for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

RECORDS REVIEWED

Notification of IRO assignment, information provided by The Requestor, Respondent, and Treating Doctor(s), including: IRO request, Summit Rehab Centers Position Statement report dated 1-4-06, HEB Bone & Joint Surgeons report dated 1-25-2005, Designated Doctors exam 2-2-05, Operative report right knee dated 2-28-05, Script for PT from HEB Bone & Joint, Office visit Total Pain Medicine & Anesthesiology 4-18-05, Designated Doctor report MMI 8-25-05, West-East Medical & Rehab IR report dated 8-28-05, Several pages of supporting guidelines for rehab and post-op, 53+ pages Clinical SOAP notes from Dr. Luz Gonzalez, DC, FCE dated 3-15-2005, 4-12-2005, 5-6-2005, Ergos Evaluation Summary report 5-20-2005, Notice of IRO assignment, MR-117 TDI form, TWCC(TDI)-60 form with table, 14 pages EOBs associated dates

CLINICAL HISTORY

The Patient apparently sustained a work related injury on ____, when The Patient slipped on an oil slick and injured his right knee and low back. On 2-17-2004, The Patient was seen by Dr. Roger, who prescribed medication. On 4-14-2004, or thereabouts, The Patient began to see Dr. Gonzalez a local chiropractor. On 4-15-2005, The Patient was seen by a Dr. Small, who prescribed medication. On 5-29-2004, MRI of the right knee and lumbar spine was performed. MRI of the lumbar spine revealed disc bulges at L3-4, L4-5, and L5-S1. MRI of the right knee revealed a subtle tear within the posterior horn of the medial and lateral meniscus. The patient was seen by Dr. Payne, who is apparently a neurosurgeon, and LESI were recommended. On 7-7-2004, The Patient was seen for a Designated Doctor Examination with Dr. Personett MD, who stated he was not at MMI. On 7-06-2004, EMG/NCV was suggestive of bilateral L4-5 radiculopathy. On 7-13-2004, Dr. Farhat diagnosed The Patient was lumbar disc displacement. On 8-06-2004, The Patient was evaluated by Mr. Bohart and recommendations were made for psychotherapy along with PT. The Patient underwent right knee arthroscopy with partial synovial resection on 2-28-2005. The Patient was apparently cleared for post-operative therapy sometime towards the end of March 2005. On 2-2-2005, The Patient was seen for a Designated Doctor

Examination with Dr. Personett MD, who stated he was not at MMI. The Patient underwent a return to program. Eventually, on 8-25-2005 The Patient was referred to Dr. Jack Mikeworth DC for MMI/IR and assessed at MMI on 8-25-2005 with a 7% WP IR.

DISPUTED SERVICE (S)

Under dispute is the retrospective medical necessity of 99213-OV, 95851-ROM, G0283-ELECTRICAL STIMULATION, 97116-GAIT TRAINING, 97140-MANUAL THERAPY TECHNIQUE, 96004-PHYSICIAN REVIEW OF MOTION TEST, 97110-THERAPEUTIC EXERCISES, G0283-ELECTRICAL STIMULATION, 95831-MUSCLE TESTING, 97124-MASSAGE, 97750-FCE- FCE denied by insurance carrier for medical necessity (1-19-05 thru 7-15-05).

DETERMINATION / DECISION

The Reviewer disagrees with the determination of the insurance carrier.

RATIONALE/BASIS FOR THE DECISION

Based on the clinical evidence and documentation, The Reviewer assessment is that the disputed services were medically necessary. The Patient underwent a right knee repair on 2-28-2005 and was released for post-op rehabilitation on 3-15-2005. Medical documentation supports post-operative therapy. Records reflect continued progression and significant improvement throughout care. Medical necessity is additionally supported by other physicians from different specialties. Additionally, other providers/records supported the medical necessity throughout care.

Screening Criteria

1. Specific:

Clinical Orthopedic , S. Brent Brotzman & K. Wilk 2nd Ed.
Mosby

2. General:

In making his determination, the Reviewer had reviewed medically acceptable screening criteria relevant to the case, which may include but is not limited to any of the following: Evidence Based Medicine Guidelines (Helsinki, Finland); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Texas Chiropractic Association: Texas Guidelines to Quality Assurance (Austin Texas); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Mercy Center Guidelines of Quality Assurance; any and all guidelines issued by DWC or other State of Texas Agencies; standards contained in Medicare Coverage Database; ACOEM Guidelines; peer-reviewed literate and scientific studies that meet nationally recognized standards; standard references compendia; and findings; studies conducted under the auspices of federal government agencies and research institutes; the findings of any national board recognized by the National Institutes of Health; peer reviewed abstracts submitted for presentation at major medical associates meetings; any other recognized authorities and systems of evaluation that are relevant.

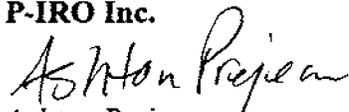
CERTIFICATION BY OFFICER

P-IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. P-IRO has made no determinations regarding benefits available under the injured employee's policy.

As an officer of P-IRO Inc., I certify that there is no known conflict between the Reviewer, P-IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

P-IRO is forwarding by mail or facsimile, a copy of this finding to the DWC.

Sincerely,
P-IRO Inc.


Ashton Prejean

President & Chief Resolutions Officer

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.

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

I hereby certify, in accordance with DWC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent DWC via facsimile, U.S. Postal Service or both on this 24th day of January, 2006.

Name and Signature of P-IRO Representative:

Sincerely,

P-IRO Inc.



Ashton Prejean

President & Chief Resolutions Officer