



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

<b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address:  Bratcher Injury and Wellness Center, P.A. 225 E. Amherst Dr., Ste C Tyler, TX 75706	MDR Tracking No.: M5-06-0717-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  Liberty Insurance Corp, 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, "Peer review doctor did not have our documentation to back up the medical necessity since the insurance carrier did not forward the documents to him."

#### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response.

#### 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)
7-13-05	CPT code 97535	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$35.63
6-8-05 – 8-3-05	CPT codes 98940, 98943, G0283, 97110, 97024, 95925-TC	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0

#### 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 majority of the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$35.63.

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 2-16-06 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.

Regarding CPT code 99213-25 on 6-8-05: The reconsideration EOB shows a denial code of "18-Duplicate". The insurance carrier states in its response that this service had already been reimbursed and the insurance carrier states that there was "inappropriate billing". However, the requestor states this service has not been reimbursed to this HCP. They billed with

the modifier "25 - Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service." Recommend reimbursement of requestor's billed amount of \$59.00.

CPT code E0745-NU on 7-13-05 was denied as "X-170-Preauthorization was required, but not requested for this service." This is not a TENS unit and does not exceed \$500.00; therefore it does not require preauthorization. Recommend reimbursement of requestor's billed amount of \$495.00 which is less than the MAR as shown on the DMEPOS Fee Schedule.

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

28 Texas Administrative Code Sec. 133.308 and 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 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 for the services involved in this dispute in the amount of \$589.63. 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

\_\_\_\_\_  
Typed Name

3-6-06

\_\_\_\_\_  
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.**

# IRO America Inc.

**An Independent Review Organization**

**7626 Parkview Circle**

**Austin, TX 78731**

Phone: 512-346-5040

**Fax: 512-692-2924**

Amended February 15, 2006

February 14, 2006

TDI-DWC Medical Dispute Resolution

Fax: (512) 804-4868

Patient:

TDI-DWC #:

MDR Tracking #:

M5-06-0707-01

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

IRO America 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; the Reviewer is a credentialed Panel Member of IRO America's Medical Knowledge Panel who is a licensed Provider, board certified and specialized in Chiropractic Care. The reviewer is on the DWC Approved Doctor List (ADL).

The IRO America 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, Medical Records from Requestor, Respondent, and Treating Doctor (s), including: EOB's, FCE notes, notes from Kenneth Wise Psy. D, lower extremity NCV/EMG, lumbar X-ray and MRI, abdomen CT, notes from Michelle Ivey DC, notes from Hooman Sedighi MD, rehab daily notes, notes from Marlon Padilla MD, notes from Carey Fabacher DC.

### **CLINICAL HISTORY**

This Patient was injured on Octobe\_\_\_\_, 2004, in a work related accident. The Patient was lifting and bending, stacking lawn mowers weighing 100+ pounds when he felt low back pain and stomach pain.

### **DISPUTED SERVICE (S)**

Under dispute is the medical necessity of work hardening-97545, work hardening each additional hour-97546, and functional capacity exam-97750 for dates of service 12/23/2004 through 1/14/2005.

### **DETERMINATION / DECISION**

The Reviewer disagrees with the determination of the insurance carrier in this case.

### **RATIONALE / BASIS FOR DECISION**

Under the *Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters*, and the *Official Disability Guidelines*, the treatment rendered in this case appears reasonable and medically necessary. According to these screening criteria's, it is imperative to progress the patient into an aggressive active rehab program or work conditioning/ work hardening program as soon as safely possible. The Treating Doctor takes into consideration, the importance of moving The Patient out of a passive phase of care into an active phase of care in a timely manner. If a patient is in a passive phase of care too long, it promotes doctor dependency, somatization, chronicity and possible doctor over-utilization, which is not evident in this case. Therefore, the disputed treatment under the disputed time, is reasonable and medically necessary.

#### **1. Screening Criteria**

- Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters
- Official Disability Guideline

#### **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

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

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

IRO America is forwarding by facsimile, a copy of this finding to the DWC.

Sincerely,

**IRO America Inc.**



Dr. Roger Glenn Brown

**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 to DWC via facsimile, on this 15th day of February, 2006.

Name and Signature of IRO America Representative:

Sincerely,

**IRO America Inc.**



Dr. Roger Glenn Brown

**President & Chief Resolutions Officer**