



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 Dispute

#### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address:	MDR Tracking No.: M5-06-0729-01
Horizon Health % Bose Consulting, L. L. C. P. O. Box 550496 Houston, Texas 77255	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  Insurance Company of the State of PA, Box 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

#### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position Summary states, "...the treatment provided for the claimant was medically reasonable and necessary. We are requesting reimbursement for all disputed dates of services."

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. CMS-1500's
3. EOB's

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

Position Summary (Table of Disputed Services) states, "Based on RME, no further treatment R or N."

Principle Documentation:

1. DWC-60/Table of Disputed Service

#### 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)
2-7-05 – 4-1-05	99212 (\$48.03<MAR x 16 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$768.48
2-7-05 – 4-1-05	99213 (\$67.20 x 2 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$134.40
2-7-05 – 4-1-05	97110 (\$35.86 x 114 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$4,088.04
2-7-05 – 4-1-05	97112 (\$36.75<MAR x 18 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$661.50
2-7-05 – 4-1-05	97140 (\$33.91<MAR x 18 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$610.38
	Grand Total		\$6,262.80

#### 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.

Per Rule 134.202(d), reimbursement shall be the least of the (1) MAR amount as established by this rule or, (2) the health care provider's usual and customary charge).

The Division has reviewed the enclosed IRO decision and determined that the Requestor did prevail on the disputed medical necessity

issues. Per Rule 134.202(d)(2) the amount due the Requestor for items denied for medical necessity is \$6,262.80.

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 8-03-06 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 codes 99212, 97110, 97112, and 97140 from 3-07-05 through 3-11-05 were denied by the Respondent as "3V-Extent of injury. Not finally adjudicated." In a telephone call on 2-10-06 the adjustor affirms that there was an RME on 10-04-05 and there are no extent issues. No TWCC-21 or PLN-11 has been filed by the Respondent regarding extent of injury. Reimbursement recommended per the 2002 Medical Fee Guideline as follows:

99212 (\$48.03<MAR x 3 DOS) = \$144.09

97110 (\$35.86 x 18 units) = \$645.48

97112 (\$36.75<MAR x 3 units) = \$110.25

97140 (\$33.91<MAR x 3 units) = \$101.73

Regarding CPT code 99080-73 on 4-14-05: The Respondent denied this service as "W-9-disallowed based on the results of a peer review." The DWC-73 is a required report per Rule 129.5 and cannot be denied for medical necessity. Recommend reimbursement of \$15.00 according to 129.5.

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

Texas Labor Code 413.011(a-d) and 413.031

28 Texas Administrative Code Sec. 129.5, 133.106, 133.308, 134.1, 134.202

#### 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 Respondent 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 \$7,279.35. The Division hereby **ORDERS** the Respondent 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 by:

Medical Dispute Officer

10-13-06

Order by:

Manager, Medical Dispute Resolution

Authorized Signature

Typed Name

#### 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

Amended October 4, 2006  
September 20, 2006

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

Patient:  
TDI-DWC #:  
MDR Tracking #: M5-06-0729-01  
IRO #: 5251

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, records from the Requestor, Respondent, and Treating Doctor(s), including but not limited to: IRO request, 4-pages Position Statement, 2-pages MRI of Cervical Spine dated 8-23-04, page 3 of report Dr. Benjamin Agana, 3-page report by Jeffrey Reuben, 3-page Initial Consult Dr. Bobby Pervez dated 12-20-04, Follow-up Dr. Bobby Pervez dated 2-21-05, 4-18-05; Operative report Dr. Bobby Pervez dated 3-31-05, 8-pages Initial Consult report Dr. Peter Yeh dated 10-26-04, 2-pages Initial Consult report Dr. Carrie Schwartz dated 7-16-04, Subsequent report Dr. Carrie Schwartz dated 8-30-04, 4-pages RME dated 8-30-05, Daily Notes dated 4-11-05, 4-13-05, 4-15-05, 1-7-05, 8-21-05, 4-4-05, 4-6-05, 4-8-05, 3-28-05, 3-30-05, 4-1-05, 3-21-05, 3-23-05, 3-25-05, 3-14-05, 3-16-05, 3-18-05, 3-7-05, 3-9-05, 3-11-05, 2-28-05, 3-2-05, 3-4-05, 2-21-05, 2-23-05, 2-25-05, 2-14-05, 2-16-05, 2-18-05, 2-7-05, 2-9-05, 2-11-05, 1-31-05, 2-2-05, 2-4-05, 1-24-05, 2-16-05, 1-28-05, 1-17-05, 1-19-05, 1-21-05, 1-10-05, 1-12-05, 1-14-05, 1-3-05, 1-5-05, 1-7-05, 12-27-04, 12-28-04, 12-29-04, 12-20-04, 12-22-04, 12-23-04, 12-15-04, 12-16-04, 12-17-04, 12-6-04, 12-8-04, 12-10-04; 3-pages DD evaluation Dr. Benjamin Agana dated 5-2-05.

#### CLINICAL HISTORY

The Patient apparently sustained a work related injury on \_\_\_\_\_. She was apparently working on a construction site, when she bent down to pick up some material and a board from a piece of wall fell and struck her in the head, knocking her backward. She was referred to the company doctor, and was diagnosed with facial scalp contusion. She was placed at MMI and released. She continued to experience increasing pain; therefore, she sought treatment with Dr. Schwartz, who placed her into treatment with physical modalities. She was referred for an MRI of the cervical spine on 8-23-2004, which revealed C4-5, C5-6, and C6-7 disc pathologies. On 10-09-2004, she was referred to Dr. Ruben MD orthopedic surgeon, who prescribed medication and recommended injections. She apparently underwent an EMG/NCV which was reported as normal. She was referred to Dr. Yea, neurosurgeon, who recommended injections. She was referred to Dr. Pervez, MD, who performed a series of cervical epidural injections. She had a designated doctor appointment with Dr. Benjamin Agana, MD on 5-2-2005, who stated she was not at MMI and estimated MMI sometime within the next 3 months. On 8-30-2005, Dr. Schwartz, assessed her at MMI with a 5% whole person impairment.

#### DISPUTED SERVICE(S)

Under dispute is the retrospective medical necessity of office visits, therapeutic exercises, manual therapy technique and neuromuscular re-education for the dates 2/7/05 through 4/14/05.

#### DETERMINATION/DECISION

The Reviewer disagrees with the determination of the insurance company.

## RATIONALE/BASIS FOR THE DECISION

Based on the clinical evidence and documentation, the Reviewer concluded that the disputed services were medically necessary. The Patient was undergoing injections during the time in question, which did provide some relief to the Patient. Post injection therapy is highly recommended and is typically considered appropriate care. The Patient was seen by an independent designated doctor on 5-02-2005, who indicated that the Patient was not at MMI and recommended additional appropriate care. The Patient was eventually assessed at MMI on 8-3-05, which does correlate with the designated doctors recommendations. Additionally, other providers/records supported the medical necessity throughout care.

### Screening Criteria

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 literature 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 6<sup>th</sup> day of July, 2006.

Name and Signature of IRO America Representative:

Sincerely,

**IRO America Inc.**

A handwritten signature in black ink, appearing to read "Roger Glenn Brown", with a long horizontal flourish extending to the right.

Dr. Roger Glenn Brown

**President & Chief Resolutions Officer**