



## MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

### Retrospective Medical Necessity

#### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address:  SCD Back and Joint Clinic, Ltd. 200 E. 24 <sup>th</sup> Street, Suite	MDR Tracking No.: M5-06-0890-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  Trinity Universal Ins Company of KA, Box 42	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, "These services were reasonable, necessary, and related to the compensable injury. Appeals and follow up with the carrier have failed to resolve the dispute."

#### 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)
1-10-05 – 8-23-05	CPT code 99080 – medical records, 76 pages copied	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$38.00
1-10-05 – 8-23-05	CPT code 99080-73 (\$15.00 X 4 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$60.00
1-10-05 – 8-23-05	CPT code 97750 (\$35.63 X 6 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$213.78
1-10-05 – 8-23-05	CPT code 99211-25, 99211 (\$24.73 X 4 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$98.92
1-10-05 – 8-23-05	CPT code 99212-25, 99212 (\$45.26 X 9 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$407.34
1-10-05 – 8-23-05	CPT code 99213-25, 99213 (\$61.89 X 3 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$185.67
1-10-05 – 8-23-05	HCPCS code L1499	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	DOP
1-10-05 – 8-23-05	HCPCS code A4595	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$36.01
1-10-05 – 8-23-05	HCPCS code L500	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	DOP
1-10-05 – 8-23-05	CPT code 98941 (\$44.28 X 10 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$442.80
1-10-05 – 8-23-05	CPT code 97530 (\$35.15 X 29 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1019.35
1-10-05 – 8-23-05	CPT code 97112 (\$35.21 X 18 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$633.78
1-10-05 – 8-23-05	CPT codes 97024, G0283, 97012, 97124, 97026, office visits in excess of once a week	<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.

Date of service 01-07-05 per Rule 133.308(e)(1) was not timely filed and is ineligible for review.

The IRO reviewer stated that office visits were medically necessary at a frequency of no more than once per week. The first office visit in each week was recommended for reimbursement.

Some services in this dispute were denied as "W-12-extent of injury". However, a Contested Case Hearing on April 7, 2005 confirmed that the cervical, thoracic, and lumbar areas were compensable. These are the body areas for which the requestor billed. A second denial code of 855-020 (denial based upon a peer review) was also listed for these services. These services were therefore reviewed by the IRO for medical necessity.

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 \$3135.65 plus DOP amounts.

**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 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 additional reimbursement in the amount of \$3135.65 plus DOP amounts. 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:

3-1-06

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

## NOTICE OF INDEPENDENT REVIEW DECISION

February 23, 2006

Program Administrator  
Medical Review Division  
Division of Workers Compensation  
7551 Metro Center Drive, Suite 100, MS 48  
Austin, TX 78744-1609

RE: Claim #:  
Injured Worker:  
MDR Tracking #: M5-06-0890-01  
IRO Certificate #: IRO4326

TMF Health Quality Institute (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Division of Workers' Compensation (DWC) has assigned the above referenced case to TMF for independent review in accordance with DWC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, 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 was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and 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 IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

### Clinical History

This patient sustained a work-related injury on \_\_\_ when she was on a ladder and fell off backwards onto a concrete floor. This resulted in cervical, thoracic, and lumbar pain. Treatment has included physical medicine, physical therapy, and epidural steroid injections.

### Requested Service(s)

9908-73-DWC-73, 99211, 99211-25, 99212, 99212-25, 99213, 99213-25 Office Visits, 97024-Diathermy, G0283-Electrical stimulation, L1499-Cervical Pillow, L1499-Sitback rest, A4595-TENS supplies, 97012-Mechanical traction therapy, 98941-Chiropractic manipulation, 97124-59-Massage, L500-Lumbar neuromuscular re-education, 97530-Therapeutic Activities, 99080-Medical records, 97026-Low level light therapy, and 97750-Performance test provided from 01/10/2005 through 08/23/2005.

### **Decision**

It is determined that the following services provided from 01/10/2005 through 08/23/2005 were medically necessary to treat this patient's condition: 99080- medical records and report 99080-73-DWC-73, and 97750 performance test were necessary. The office visits 99211, 99211-25, 9912, 99212-25, 99213, and 99213-25 were medically necessary at a frequency of no more than once per week. The DME to include L1499-cervical pillow, L1499-sitback rest, A4595-TENS supplies, L500-lumbar support, L1499-lumbar roll, L1499-cervical roll, and L1499-Personal wedge were necessary. The 98941-chiropractic manipulation was necessary. The active therapy to included 97530-therapeutic activities and 97112-59 Neuromuscular reeducation were medically necessary.

It is determined that the following services provided from 01/10/2005 through 08/23/2005 were not medically necessary to treat this patient's condition: all passive therapy, i.e. 97024-Diathermy, G0283-electrical stimulation, 97012 mechanical traction, 97124-59-massage, 97026-low level light therapy was not medically necessary. In addition, the office visits 99211, 99211-25, 9912, 99212-25, 99213, and 99213-25 in excess of once per week were not medically necessary.

### Rationale/Basis for Decision

National treatment guidelines allow for this type of treatment for this type of injury. However, they do not allow for the intensity,

frequency of duration this patient received. The patient had received an appropriate treatment program prior to changing treating doctors. Her date of injury was 07/23/3004 and her new treating doctor's initial evaluation was 01/20/205. This was almost 6 months post injury and there are no guidelines that allow for passive therapy this long after a date of injury. She had not had a trial of chiropractic care or sufficient active therapy since her injury so these would be considered to be medically indicated. Charging for an office visit each time the patient comes in for treatment is not considered medically appropriate. Office visits on a weekly basis during treatment allow for proper management of the case. The DME supplied was necessary for the treatment of her condition. Performance testing was necessary to properly assess the patient's condition. Reports and medical records were medically necessary.

This decision by the IRO is deemed to be a DWC decision and order.

### **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,

Gordon B. Strom, Jr., MD  
Director of Medical Assessment

### **Information Submitted to TMF for Review**

**Patient Name:** \_\_\_ **Tracking #:** M5-06-0890-01

#### **Information Submitted by Requestor:**

- Letter to TMF
- Initial Medical Narrative Report
- Letter from patient
- Prescription for home exercises
- Subsequent Medical Narrative Reports
- Light Duty Clarifications
- Initial Treatment Plan
- Patient office visit reports
- Patient referrals
- Follow up visits
- Assessment/Physical Examination
- Progress notes
- Orthopedic Consultation
- Laboratory results
- Radiology Consultation Report
- Physical Therapy Notes
- MRI report of cervical spine
- Report of Medical Record Review
- Initial evaluations
- Electrodiagnostic examination
- Emergency room notes
- Report of CT brain scan
- Required medical evaluation

#### **Information Submitted by Respondent:**

- History and Physical
- Report of Medical Review
- Required Medical Evaluation