



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: Summit Rehabilitation Centers 2420 E Randol Mill Road Arlington, Texas 76011	MDR Tracking No.: M5-06-0911-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Dallas Fire Insurance Company Box 20	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

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

DOCUMENTATION SUBMITTED: DWC-60 dispute package  
POSITION SUMMARY: Per the table of disputed services "Necessary"

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

DOCUMENTATION SUBMITTED: Response to DWC-60 dispute package  
POSITION SUMMARY: "Not reasonable and medically necessary".

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
05-31-05 to 06-24-05	95832 (no reimbursement see note below) 95852 (no reimbursement see note below) G0283 (1 unit @ \$14.65 X 9 DOS) = \$131.85 99080-73 (\$15.00 X 1 DOS) = \$15.00 97140 (1 unit @ \$34.16 X 5 DOS) = \$170.80	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$317.65
05-31-05 to 06-24-05	96004, 97110 and 99213	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
	Note: CPT codes 95832 and 95852 are component procedures of CPT code 99213 billed on the same dates 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 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.

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

28 Texas Administrative Code Sec. 133.308 and 134.202(c)(1)

**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 reimbursement in the amount of \$317.65. The Division finds that the requestor was not the prevailing party and is not entitled to a refund of the IRO fee. 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:

03-20-06

\_\_\_\_\_  
Authorized Signature

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

March 17, 2006

**ATTN: Program Administrator**  
**Texas Department of Insurance/Workers Compensation Division**  
7551 Metro Center Drive, Suite 100  
Austin, TX 78744  
Delivered by fax: 512.804.4868

## Notice of Determination

MDR TRACKING NUMBER: M5-06-0911-01  
RE: Independent review for \_\_\_\_

The independent review for the patient named above has been completed.

- Parker Healthcare Management received notification of independent review on 2.7.06.
- Faxed request for provider records made on 2.10.06.
- The case was assigned to a reviewer on 3.6.06.
- The reviewer rendered a determination on 3.16.06.
- The Notice of Determination was sent on 3.17.06.

The findings of the independent review are as follows:

### Questions for Review

Medical necessity of 97110- therapeutic exercises, 97140-manual therapy tech, 99213-office visits, G0283-Electrical Stimulation, 95832-muscle test, 95852-ROM testing, 99080-73-DWC report, 96004-physician review report and interpretation computer data.  
Dates of Service: 5.31.05-6.24.05

### Determination

PHMO, Inc. has performed an independent review of the proposed care to determine if the adverse determination was appropriate. After review of all medical records received from both parties involved, the PHMO, Inc. physician reviewer has determined to **overturn the denial** on the disputed service(s): hand ROM testing (95852), the hand muscle strength testing (95832), manual therapy techniques (97140), Electrical stimulation (G0283), and the special reports (99080-73) are all approved.

PHMO, Inc. physician reviewer has also determined to **uphold the denial** on all of the disputed service(s): 97110- therapeutic exercises, 99213-office visits, 96004-physician review report and interpretation computer data.

### Summary of Clinical History

Patient is a 20-year-old male warehouseman who, on \_\_\_\_, was operating some sort of press machine when his left thumb became caught and was crushed, resulting in a traumatic amputation. He was taken to the local hospital where the amputated portion was debrided and closed. On 4.12.05, he began his post-surgical physical therapy and rehabilitation under the supervision of a doctor of chiropractic.

### Clinical Rationale

In this case, the medical records adequately documented that a compensable injury to the claimant's left thumb occurred, and that there was persistent pain, as well as decreased strength and mobility as a result of the injury. Therefore, the

medical necessity of applying myofascial release to “reduce scar tissue, pain and range of motion,” the periodic physical performance testing, application of electrical stimulation for pain management, and the periodic preparation of required reports, were all supported as medically necessary.

However, insofar as the therapeutic exercises (97110) were concerned, nothing in either the diagnosis or medical records provided supported the medical necessity for continued *supervised* therapeutic exercises after 5.31.2005. Not only was the injury limited to a relatively small body part, but also – absent any documented clinical rationale to the contrary – the patient could easily have been safely transitioned into a home program after 6 weeks of supervised exercises. This is further supported by the fact that, according to the medical literature, “...there is no strong evidence for the effectiveness of supervised training as compared to home exercises.”<sup>1</sup>

With regard to the level III established patient office visits (99213), however, nothing in either the diagnosis or the medical records supported the performance of so high an Evaluation and Management (E/M) service on each and every patient encounter, and particularly not during an already-established treatment plan. Additionally, with periodic range of motion and strength testing already occurring separately to monitor the patient’s response and progress, additional E/M service would have been duplicative, and as such, not medically necessary.

And finally, regarding the 96004, according to CPT2, this service is defined as, “Physician review and interpretation of comprehensive computer-based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report.” However, this injury does not involve the lower extremities, so “dynamic plantar measurements” and “dynamic surface electromyography during walking” are irrelevant in this case and therefore not medically necessary. Furthermore, the code requires that a written report be submitted, and upon careful review of the doctor’s records, the statement, “I reviewed and signed the Jtech ROM/MT exam given to Michael and will adjust treatment protocols as needed” is grossly insufficient to qualify as a “written report.”

Clinical Criteria, Utilization Guidelines or other material referenced

The references used in the review of this determination are shown below as footnotes.

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The reviewer for this case is a doctor of chiropractic peer matched with the provider that rendered the care in dispute. The reviewer is engaged in the practice of chiropractic on a full-time basis.

The review was performed in accordance with Texas Insurance Code 21.58C and the rules of Texas Department of Insurance /Division of Workers' Compensation. In accordance with the act and the rules, the review is listed on the DWC's list of approved providers or has a temporary exemption. The review includes the determination and the clinical rationale to support the determination. Specific utilization review criteria or other treatment guidelines used in this review are referenced.

The reviewer signed a certification attesting that no known conflicts-of-interest exist between the reviewer and the treating and/or referring 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.

The reviewer also attests that the review was performed without any bias for or against the patient, carrier, or other parties associated with this case.

### 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.

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1 Ostelo RW, de Vet HC, Waddell G, Kerchhoffs MR, Leffers P, van Tulder M, Rehabilitation following first-time lumbar disc surgery: a systematic review within the framework of the cochrane collaboration. *Spine*. 2003 Feb 1;28(3):209-18.

2 *CPT 2004: Physician's Current Procedural Terminology, Fourth Edition, Revised*. (American Medical Association, Chicago, IL 1999),

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 address for the Chief Clerk of Proceedings would be: P.O. Box 17787, Austin, Texas, 78744.

I hereby verify that a copy of this Findings and Decision was faxed to Texas Department of Insurance /Division of Workers Compensation applicable to Commission Rule 102.5 this 17<sup>th</sup> day of March, 2006. The Division of Workers Compensation will forward the determination to all parties involved in the case including the requestor, respondent and the injured worker.

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Meredith Thomas  
Administrator  
Parker Healthcare Management Organization, Inc.