



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

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

Requestor's Name and Address:

Summit Rehab. Centers  
2420 E. Randol Mill Road  
Arlington, TX 76011

MDR Tracking No.: M5-06-0937-01

Claim No.:

Injured Worker's Name:

Respondent's Name and Address:

Fidelity & Guaranty Box 19

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

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

DWC-60 package. Position Summary: Followed fee guidelines and necessary.

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

Response to DWC-60 package. Position Summary: Per billing department, bill for 10-27-05 never received.

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

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
5-27-05 to 6-23-05 and 10-18-05 to 10-27-05	99213 \$65.44 x 5 days =	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	327.20
	97018 \$8.01 x 6 days =	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	48.06
	97110 \$104.79 x 6 days =	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	628.74
	97124 \$55.62 x 1 day =	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	55.62
6-28-05 to 10-11-05	99213, 97110, 99080-73	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0.00
Total			\$1059.62

#### 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.

Requestor submitted proof of delivery for date of service 10-27-05; therefore, this date of service was submitted to the IRO.

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.

Code 95832 billed on 5-27-05 was denied as global. Per the 2002 Medical Fee Guidelines, this code is global to an office visit billed on the same date. No reimbursement recommended.

Code 99080-73 billed for date of service 7-22-05 was denied as unnecessary medical; however, per Rule 129.5, this is a required report and is not subject to an IRO review. Medical Review has jurisdiction in this matter. The work status report sent on 7-22-05 did not indicate a change in medical condition and did not describe how the injury prevented the employee from returning to work. The report was not completed in conjunction with an office visit. No reimbursement 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 \$1059.62. In addition, 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:

Medical Dispute Officer

3-29-06

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

**IRO Medical Dispute Resolution M5 Retrospective Medical Necessity  
IRO Decision Notification Letter**

<b>Date:</b>	<b>03/21/2006</b>
<b>Injured Employee:</b>	
<b>MDR #:</b>	<b>M5-06-0937-01</b>
<b>DWC #:</b>	
<b>MCMC Certification #:</b>	<b>TDI IRO-5294</b>

**REQUESTED SERVICES:**

Please review the item(s) in dispute: 99213-office visit, 97110-therapeutic exercises, 99354-prolonged physical services, 97018-paraffin bath, 97124-massage, 99080-73-DWC-60.

Dates of service (DOS): 05/27/2005-10/27/2005

**DECISION: Partial**

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IRO MCMCIIc (MCMC) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO) to render a recommendation regarding the medical necessity of the above disputed service.

**Please be advised that a MCMC Physician Advisor has determined that your request for an M5 Retrospective Medical Dispute Resolution on 03/21/2006, concerning the medical necessity of the above referenced requested service, hereby finds the following:**

The medical necessity for an initial course of chiropractic management commencing on 05/27/2005 is established. An initial course of four weeks of care through 06/23/2005 is certified as medically necessary. However, no other pre-surgical chiropractic management is certified as medically necessary. A course of post-surgical rehabilitation would be certified as medically necessary commencing on 10/18/2005 through 10/27/2005, the last date in question.

**CLINICAL HISTORY:**

Records indicate that the above captioned individual allegedly sustained injuries on \_\_\_ as the result of an occupational incident. The history reveals that the above captioned individual, during the course of her normal employment, was carrying notebooks and other items, missed a step and fell forward on her right hand and wrist. According to the Attending Physician's statements, the injured individual was initially treated by the company doctors and presented to the Attending Physician on 05/24/2005. Previous to 05/24/2005, the injured individual had been treated by a litany of doctors. Previous treatment consisted of medication management, diagnostic evaluations and physical therapy. One of the original diagnoses included a chronic compartment syndrome. An MRI had been performed on 12/20/2004, which showed inflammation around the third metacarpal phalange (MCP) joint capsule but no evidence of any fracture. There was also evidence of joint effusion and T2 hyperintensity within the third metacarpal shaft as well as the fourth metacarpal shaft. The injured individual also received a course of injections. On 07/14/2005, an arthrogram of the right wrist was performed and revealed possible scapholunate tear. A small defect was also identified within the medial edge of the triangular fibrocartilage. A post-arthrogram CT was performed which revealed findings compatible with a sprain and tear of the scapholunate ligament as well as a possible anterior tear of the lunatotriquetrel. A defect or tear in the medial aspect of the triangular fibril cartilage was also noted. Under the administration of the Attending Physician, the injured individual received a course of chiropractic management to include active and passive care. Surgery was performed on 10/07/2005. On 10/11/2005, her surgeon recommended a course of post-surgical rehabilitation. This was performed under the administration of the Attending Physician.

**REFERENCES:**

ACOEM Guidelines. Second Edition. American College of Occupational and Environmental Medicine.

**RATIONALE:**

Records reveal that the injured individual presented to the Attending Physician (AP) on or about 05/25/2005. Records do not adequately reveal what degree, type, or amount of physical therapy had been attended prior to 05/24/2005. However it is not clear that she had received an adequate course of care which could have been reasonably expected to progress her to pre-injury status especially given the internal derangement revealed in the advanced testing. Objective testing dated 05/27/2005 also revealed significant range of motion deficits. Therefore, a trial of chiropractic management to include active and passive care is certified as medically necessary. However, there is no evidence that any follow-up evaluations were performed beyond the initial collection of objective data to ascertain if the injured individual was continuing to make progress. Furthermore, daily notes do not indicate that subjectively the injured individual was continuing to make progress. In fact, subjective pain levels were actually increased over the initial course of care. Therefore, no additional pre-surgical chiropractic care beyond 06/23/2005, the initial four weeks of care, would be certified as medically necessary.

The injured individual underwent surgery on 10/07/2005. Consistent with ACOEM guidelines as well as standards of practice and care within the chiropractic profession, a course of post-surgical rehabilitation would be certified as medically necessary. Objective testing revealed deficits in ranges of motion. This course of post-surgical rehabilitation commenced on 10/18/2005. The final date of service in dispute posed to this reviewer is 10/27/2005. A course of post-surgical rehabilitation would be certified through that date.

**RECORDS REVIEWED:**

- Notification of IRO Assignment dated 02/09/06
- MR-117 dated 02/08/06
- DWC-60
- DWC-69: Report of Medical Evaluation
- MCMC: IRO Medical Dispute Resolution Retrospective Medical Necessity dated 02/21/06
- MCMC: IRO Acknowledgment and Invoice Notification Letter dated 02/10/06
- Summit Rehab Centers: Doctor's Position Statement dated 02/15/06 from R. Todd Petersen, D.C.
- William J. Van Wyk, M.D.: Established Patient Follow-up/Post Op Visit note dated 11/02/05
- Andrew B. Small, III., M.D.: Office notes dated 11/01/05, 08/09/05, 07/12/05, 06/07/05
- Patient Therapy Report (handwritten) dated 10/11/05 from Blake Knox, OTR
- William J. Van Wyk, M.D.: Prescription for Hand Therapy notes dated 10/11/05, 09/26/05
- Ft. Worth Surgery Center: Operative Report dated 10/07/05 from William Van Wyk, M.D.
- William J. Van Wyk, M.D.: Handwritten report dated 09/26/05
- William J. Van Wyk, M.D.: X-Ray Report dated 09/26/05
- Total Pain Medicine and Anesthesiology: Office Visit note dated 08/16/05 from George Farhat, M.D.
- Broad Spire: Letter dated 07/26/05 from Carol Spitzer, Claim Specialist
- Total Pain Medicine and Anesthesiology: Office Procedure Note dated 07/20/05 from George Farhat, M.D.
- Central Imaging: Arthrogram of the right wrist, CT of the right wrist dated 07/14/05
- Central Imaging: History and Physical dated 07/14/05 from Phyllis Frostenson, M.D.
- George Farhat, M.D.: Page 3 of Initial Consultation dated 07/13/05 (pages 1 and 2 not available)
- Wood Forest Chiropractic Clinic: Designated Doctor Evaluation dated 07/08/05 from Dr. Edward Tang
- Frank Swords, D.O.: Worker's Comp Report dated 08/16/05
- RHD Memorial Medical Center: Plastics Consultation dated 06/09/05 from Robert Ippolito, M.D.
- Luz D. Gonzalez, D.C.: Clinical S.O.A.P. Notes dated 05/27/05 through 10/27/05
- Summit Rehab Centers: Report dated 05/27/05
- Walter D. Gracia, M.D.: Letter dated 02/01/05

The reviewing provider is a Licensed/Boarded Chiropractor and certifies that no known conflict of interest exists between the reviewing Chiropractor 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 carrier health care providers who reviewed the case for decision prior to referral to the IRO. The reviewing physician is on DWC's Approved Doctor List.

This decision by MCMC is deemed to be a Division decision and order (133.308(p) (5)).

### **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.

**In accordance with Division rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent via facsimile to the office of DWC on this**

**21<sup>st</sup> day of March 2006.**

**Signature of IRO Employee:** \_\_\_\_\_

**Printed Name of IRO Employee:** \_\_\_\_\_