



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 Rehabilitation Centers 2420 E Randol Mill Rd. Arlington TX 76011	MDR Tracking No.: M5-06-0939-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Insurance Company, Box 54	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, "Provider sent a request for reconsideration. Proof that carrier received request is also included. Carrier chose not to respond within the 28 day time frame rule."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response. Position summary states, "Texas Mutual requests that the request for dispute resolution filed be conducted under the provisions of the APA set out above."

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)
6-7-05 – 9-7-05	CPT code 97110 (\$34.93 X 10 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$349.30
6-7-05 – 9-7-05	CPT code 97140 (\$33.04 X 6 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$198.24
6-7-05 – 9-7-05	CPT code 99213 (\$65.44 X 12 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$785.28
6-7-05 – 9-7-05	CPT code 97116 (\$30.65 X 2 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$61.30
6-7-05 – 9-7-05	CPT code 97124 (\$27.81 X 2 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$55.62
6-7-05 – 9-7-05	CPT code 96004	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$150.76
9-8-05 – 10-19-05	CPT codes 97110, 97140, 99213, 97116, 97124, 96004	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
	Grand total		\$1,600.50

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 prevail on the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$1,600.50.

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.

CPT codes 95833 and 95851 on 7-1-05 and 8-12-05 were both denied by the carrier as “97-payment is included in the allowance for another procedure/service.” These codes are considered by Medicare to be a component procedure of CPT code 99213 which was billed on these 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. The requestor will be billed for inappropriate billing per Rule 134.202(b).

CPT code 99080-73 on 9-16-05 was denied by the carrier as “29-The time limit for filing has expired.” The EOB showed the date of service to be 9-16-04. However, the requestor provided a copy of the CMS 1500 which showed that the date of service was 9-16-05. In accordance with Rule 129.5, the requestor submitted a copy of this report. Recommend reimbursement of \$15.00.

CPT code 99213 on 10-19-05 was denied by the carrier as “201-Two office visits were billed on the same day.” The requestor provided a copy of the CMS 1500 which showed that only one office visit was billed for date of service 10-19-05. Recommend reimbursement of \$65.44.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and Rule 129.5 and 134.202(b) and (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 reimbursement in the amount of \$1,680.94. 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

Donna Auby

Typed Name

5-3-06

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.



PROFESSIONAL ASSOCIATES

NOTICE OF INDEPENDENT REVIEW

NAME OF PATIENT: _____
IRO CASE NUMBER: M5-06-0939-01
NAME OF REQUESTOR: Summit Rehabilitation Centers
NAME OF PROVIDER: Luz Gonzalez, D.C.
REVIEWED BY: Licensed by the Texas State Board of Chiropractic Examiners
IRO CERTIFICATION NO: IRO 5288
DATE OF REPORT: 04/20/06

Dear Summit Rehabilitation Centers:

Professional Associates has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO) (#IRO5288). Texas Insurance Code Article 21.58C, effective September 1, 1997, allows a patient, in the event of a life-threatening condition or after having completed the utilization review agent's internal process, to appeal an adverse determination by requesting an independent review by an IRO.

In accordance with the requirement for TDI-Division of Workers' Compensation (DWC) to randomly assign cases to IROs, DWC has assigned your case to Professional Associates for an independent review. The reviewing physician selected has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, the reviewing physician reviewed 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.

This case was reviewed by a physician reviewer who is Licensed in the area of Chiropractics and is currently listed on the DWC Approved Doctor List.

I am the Secretary and General Counsel of Professional Associates and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him 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 Independent Review Organization.

REVIEWER REPORT

Information Provided for Review:

An evaluation with an unknown provider (no name or signature was available) dated 07/21/04
An MRI of the lumbar spine interpreted by Eric S. Bennos, M.D. dated 12/30/04
An operative report from R. Craig Saunders, M.D. dated 02/21/05
An evaluation with Robert T. Myles, M.D. dated 05/12/05
Evaluations with Luz D. Gonzalez, D.C. dated 05/31/05, 06/07/05, 08/23/05, 09/07/05, 09/16/05, 10/07/05, 10/14/05, and 10/19/05
Evaluations with John A. Sazy, M.D. dated 06/27/05 and 10/03/05
Chiropractic therapy was performed with Dr. Gonzalez on 06/29/05, 06/30/05, 07/01/05, 07/06/05, 07/11/05, 07/19/05, 07/25/05, 08/02/05, 08/03/05, 08/04/05, 08/10/05, 08/12/05, 08/17/05, 08/29/05, 09/09/05, 09/19/05, 09/26/05, and 10/03/05
Evaluations with George A. Farhat, M.D. dated 07/11/05, 08/09/05, and 09/08/05
A procedure report from Dr. Farhat dated 07/29/05
A Designated Doctor Evaluation from Anil T. Bangale, M.D. dated 11/14/05
A letter of authorization from Oscar T. Kirksey, B.A., D.C. at The Hartford dated 01/25/06

Letters of approval from St. Paul Travelers dated 03/13/06 and 03/14/06

A letter requesting an IRO from LaTrece E. Giles, R.N. at Texas Mutual Insurance Company dated 03/23/06

A Doctor's position statement for an IRO from R. Todd Petersen, D.C. dated 03/23/06

Clinical History Summarized:

An MRI of the lumbar spine interpreted by Dr. Bennos on 12/30/04 revealed facet arthrosis of the lumbar spine, disc protrusions at L4-L5 and L5-S1, disc desiccation at L5-S1, and lumbar hypolordosis. A lumbar epidural steroid injection (ESI) was performed by Dr. Saunders on 02/21/05. Chiropractic therapy was performed with Dr. Gonzalez from 06/29/05 through 10/03/05 for a total of 18 sessions. Dr. Farhat performed a caudal ESI on 07/29/05. On 10/03/05, Dr. Sazy recommended completing the ESI series and physical therapy. On 11/14/05, Dr. Bangale felt the patient was not at Maximum Medical Improvement (MMI) since surgery apparently was being recommended. On 01/25/06, The Hartford wrote a letter of authorization for six visits of therapy and a Functional Capacity Evaluation (FCE). On 03/13/06 and 03/14/06, St. Paul Travelers wrote a letter of approval for a third ESI and six sessions of physical therapy. Ms. Giles, of Texas Mutual Insurance Company, wrote a letter regarding an IRO on 03/23/06. On 03/23/06, Dr. Petersen wrote a letter describing the doctor's position statement for an IRO.

Disputed Services:

Therapeutic exercises, manual therapy techniques, office visits, gait training, massage therapy, and 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 from 06/07/05 through 10/19/05

Decision:

I partially agree with the requestor. The therapeutic exercises (97110), manual therapy techniques (97140), office visits (99213), gait training (97116), massage therapy (97124), and 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 (96004) from 06/07/05 through 09/07/05 were reasonable and necessary. These services from 09/08/05 through 10/19/05 would be neither reasonable nor necessary.

Rationale/Basis for Decision:

Based upon the documentation provided by Summit Rehabilitation, a letter signed by Todd Petersen, D.C., referred to SOAH decisions 453-04-1979.M5 and 453-04-0046.M5, both of which indicate one office visit per week as medically necessary determined by the administrative law judge. Upon review of the aforementioned SOAH decisions, treatment frequency of one time per week was shown to be reasonable and necessary in a patient who showed reasonable progression secondary to such treatment. Based upon the medical documentation provided by Summit Rehabilitation, the patient's condition did not show reasonable improvement. The pain scores remained at 5-6/10 on the visual analog scale (VAS) throughout all the treatment provided. Therefore, there appeared to be no progression towards recovery or even pain relief with regard to the patient's position secondary to the chiropractic treatment provided. Dr. Petersen went on to indicate that the six physical therapy or occupational therapy sessions were performed following the two week period after ESIs would be considered medically reasonable and necessary. I agree with this statement that the treatment provided with Dr. Gonzalez on 08/02/05, 08/03/05, 08/17/05, 08/23/05, 08/29/05, and 09/07/05 was reasonable and necessary. The treatment performed between 06/07/05 and 09/07/05 would be the extent of what would be allowable with regard to this IRO referral. Treatment performed from 09/08/05 through 10/19/05 would not be considered reasonable and necessary as related to the documentation provided in this IRO referral.

The rationale for the opinions stated in this report are based on clinical experience and standards of care in the area as well as broadly accepted literature which includes numerous textbooks, professional journals, nationally recognized treatment guidelines and peer consensus.

This review was conducted on the basis of medical and administrative records provided with the assumption that the material is true and correct.

This decision by the reviewing physician consulting for Professional Associates is deemed to be a Division decision and order.

YOUR RIGHT TO REQUEST A HEARING

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. A request for a hearing should be faxed to 512-804-4011 or sent to:

Chief Clerk of Proceedings/Appeals Clerk
TDI-Division of Workers' Compensation
P. O. Box 17787
Austin, TX 78744

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization's decision was sent to DWC via facsimile or U.S. Postal Service on 04/20/06 from the office of Professional Associates.

Sincerely,

Lisa Christian
Secretary/General Counsel