



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

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address:	MDR Tracking No.: M5-06-0961-01
Ft. Worth Rehab Group/Administrative Office 3500 Oak Lawn, Suite 380 Dallas, TX 75219	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
American Home Assurance Company, Box 19	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, "We are requesting that the carrier be ordered to pay these reasonable and necessary medical bills."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response. Position summary states, "The bills were denied as unnecessary medical, the Carrier's original audit stands."

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)
8-18-05 – 10-13-05	CPT code 99211 (\$26.25 X 17 DOS) + (\$18.00<MAR X 2 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$482.25
8-18-05 – 10-13-05	CPT code 97110 (\$34.92 X 66 Units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2304.72
8-18-05 – 10-13-05	CPT codes 97010, 97032, 95851-59, 95831-59, 97530, 97112, 97124	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
	Grand total		\$2786.97

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 majority of the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$2786.97.

Regarding CPT code 97110 on 8-29-05: The requestor billed for 3 units of this service. The amount the requestor listed on the Table as the amount in dispute is \$104.77. The carrier has reimbursed \$104.73. Recommend reimbursement of \$.04.

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 \$2,787.01. 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:

Donna Auby

3-20-06

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.



Specialty Independent Review Organization, Inc.

March 16, 2006

DWC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient:
DWC #:
MDR Tracking #: M5-06-0961-01
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI-Division of Workers' Compensation has assigned this case to Specialty IRO for independent review in accordance with DWC Rule 133.308, which allows for medical dispute resolution by an IRO.

Specialty IRO has performed an independent review of the care rendered 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.

This case was reviewed by a licensed Chiropractor. The reviewer is on the DWC ADL. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

The records that were received and reviewed indicated that ___ was working for Wal-Mart when he was injured in a work related accident on ___. Mr. ___ was working as a salesperson when he was attempting to load furniture into a vehicle for a customer and one of the pieces of furniture started to fall. Mr. ___ attempted to catch the falling furniture injuring his back and complained of pain in his lumbar region with burning pain into the left leg. Mr. ___ presented to Dr. Kamath for evaluation and management of his injuries on 7-18-2005.

RECORDS REVIEWED

Numerous EOB's
Dispute Resolution Paperwork
Letter of Medical Necessity from Dr. Kamath
Healthsouth Lumbar MRI
Records from Dr. Aggarwal
Reports from Unimed
Report from Dr. Liebman
Records from Central Dallas Rehabilitation Diagnostic Center
Records from Fort Worth Rehab Group
Report from Arkansas Claims Management
Reports from Consilium MD

Records from Concentra
Records from Dr. Kamath
Reports from Dr. Wilson

DISPUTED SERVICES

The items in dispute are the retrospective medical necessity of office visit (99211), neuromuscular re-education (97112), massage (97124), therapeutic exercises (97110), hot/cold packs (97010), therapeutic activities (97530), electrical stimulation (97032), range of motion (95851-59) and manual muscle testing (95831-59) from 8/18/2005 to 10/13/2005.

DECISION

The reviewer agrees with the previous adverse determination regarding 97010, 97032, 95851-59, 95831-59, 97530, 97112 and 97124.

The reviewer disagrees with the previous adverse determination regarding 99211 and 97110.

BASIS FOR THE DECISION

The basis for the determination is based upon the Medical Disability Advisor, the Official Disability Guidelines, and Evidence Based Medicine Guidelines. The Medicare guidelines and payment policies were also utilized in the decision making process of this review. Medicare payment policies state, "for all PM&R modalities and therapeutic procedures on a given day, it is usually not medically necessary to have more than one treatment session per discipline. Depending on the severity of the patient's condition, the usual treatment session provided in the home or office setting is 30 to 45 minutes. The medical necessity of services for an unusual length of time must be documented." The treating doctor does not provide adequate documentation as to why the patient would need more than 45 minutes of combined rehabilitation per day. During the timeframe of this review, the patient underwent numerous invasive procedures including ESI's, which would account for the necessity of continued rehabilitative exercises. The documentation does not support the continued need of passive therapies or manual treatment measures one month of the date of injury. In addition, it would exceed the 45-minute timeframe. The MDA gives approximately 3 months for the duration of length of disability for this type of injury as identified below, but the patient had a complicating condition of significant disc injuries and radiculopathy. The patient also underwent numerous invasive procedures, which would require post rehabilitative care for each procedure. Given the fact that the patient initiated care with Dr. Kamath in July and the services under review are within three months of the initiation of Dr. Kamath's treatment, the timeframe of treatment is within normal treatment patterns. In regards to the range of motion testing and muscle testing of the patient, there is no documented change in the treatment plan after the testing and no rationale given for performing these services. The office visits would be appropriate to monitor and evaluate the patient's care and to determine the necessary treatment protocol for the patient.

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that the reviewing provider has no known conflicts of interest between that provider 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 before referral to the IRO.

Sincerely,

Wendy Perelli, CEO

CC: Specialty IRO Medical Director

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,

Wendy Perelli, CEO

I hereby certify, in accordance with DWC- Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the Division via facsimile, U.S. Postal Service or both on this 16th day of March 2006

Signature of Specialty IRO Representative:

Name of Specialty IRO Representative: Wendy Perelli