



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:	MDR Tracking No.: M5-06-0986-01
James Tanner, D. C. 5350 Staples Ste. 210 Corpus Christi, Texas 78411	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:
Phoenix Insurance Company, Box 05	

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 package. Position summary states, "All injured worker's doctors support continued physical therapy during the course of service mentioned."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response. Position summary states, "Per RME, claimant requires no further formal physical therapy."

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)
2-7-05 – 3-28-05	CPT code 97110 (\$33.56 X 54 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,812.24
2-7-05 – 3-28-05	CPT codes 99213,G0283, 97035, 97140	<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.

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 \$1,812.24.

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.

On 2-15-06 the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Regarding CPT code 99455-V5-WP on 2-15-05: Neither the carrier nor the requestor provided EOB's. This CPT code is for a Disability Exam with a high level office visits. The office notes suggest that the service performed was for the review of a report. In accordance with 134.202(b): for billing, reporting, and reimbursement of professional medial services, Division of Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies. Recommend no reimbursement.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 129.5, 133.307, 133.308 and 134.202.

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 \$1,812.24. 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

3-10-06

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.



Specialty Independent Review Organization, Inc.

March 8, 2006

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

Patient:
DWC #:
MDR Tracking #: M5-06-0986-01
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The 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

___ was injured on ___ while performing duties for Toshiba America Business Solutions. The records indicate he was injured while team pushing a large crated copier. The records indicate the knee was hyper-extended causing his compensable injury. He has treated with James Tanner DC. He was provided with a surgical repair of medial and lateral meniscectomies with chondroplasty of the medial patellofemoral articulation in July of 2004 by Charles Breckenridge, MD. Bruce Alter, MD saw him as a designated doctor and found him to not be at MMI in June of 2004. A second designated doctor saw him in February of 2005 who opined that he had not reached MMI and should "follow up with the treating physician for further work-up and treatment". There appears to be an issue with the left ankle as well as with the knee.

RECORDS REVIEWED

Records were received from the respondent and from the requestor/treating doctor. Records from the respondent include the following: 2/21/06 handwritten letter by C. Rogers, 7/13/04 script by Orthopedic Associates of Corpus Christi (OACC), 7/22/04-4/19/05 dictation from OACC and 1/5/05 report by Michael LeCompta, DO.

Records from the requestor/treating doctor include the following: 11/20/05 request for reconsideration letter by Dr. Tanner, 2/7/05 through 3/28/05 letters by Dr. Tanner, patient progress records 2/11/05 through 3/16/05, 7/1/05 FCE, 4/27/04 left knee MRI, TWCC 73's by OACC, 5/28/04 through 4/19/05 dictation from OACC, 2/4/05 DD report by Jerry Bane, MD and DD report by Bruce Alter, MD.

DISPUTED SERVICES

The disputed services include office visits (99213-OV), electrical stimulation (G0283), ultrasound (97035), therapeutic exercises (97110) and manual therapy technique (97140) from 2/7/05 through 3/28/05.

DECISION

The reviewer agrees with the previous adverse determination regarding codes 99213, G0283, 97140 and 97035 on each date of service under review.

The reviewer disagrees with the previous adverse determination regarding code 97110 (times 3 units) on each date of service under review.

BASIS FOR THE DECISION

The reviewer notes that the patient's pain scale did not improve during the period of care under review. The reviewer notes that on the lifting station, the patients' shoulder level lifting did not improve during the period under review while the waist level improved in the number of repetitions by "5". The exercise bike increased by two minutes and one level, the treadmill was added to the program as of 2/25/05 and the ROM stayed the same during this period.

The reviewer notes that the code 99213 is not documented in the information provided from either party. As per Medicare and DWC protocols, all services must be appropriately documented to be considered for payment. Therefore, this service is denied as not properly documented.

The reviewer indicates that as per Medicare Guidelines and Protocols, 30-45 minutes of therapeutics are the accepted time period on a per visit basis. This is generally an acceptable per visit length of treatment for a knee injury. This appears to be what was provided by this provider.

Regarding continued electrotherapy, the notes indicate that Mr. ___ has a portable stimulation unit for home use. This would seem to preclude continued in office stimulation. Manual therapy would not be appropriate at this stage of care.

Regarding rehabilitative care, the notes of prior rehabilitation have not been provided by either party to the claim. This makes it very difficult, according to the reviewer, to determine what care has been provided in an active care setting. As per the examination done by Dr. Bane, the patient is in need of continued care as of early February 2005. Therefore, the active rehabilitation is approved during the period under review.

REFERENCES

Shelbourne KD, Patel DV, Adsit WS, Porter DA. Rehabilitation after meniscal repair. Clin Sports Med. 1996 Jul;15(3):595-612

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 TDI/DWC- Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the DWC via facsimile, U.S. Postal Service or both on this 8th day of March 2006

Signature of Specialty IRO Representative:

Name of Specialty IRO Representative: Wendy Perelli