



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.: M5-06-1028-01
JCMLR P.O. Box 1660 San Antonio, TX 78228	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
TX Mutual Insurance Company, Box 54	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, "I formally request reconsideration regarding your denial of payment for all service provided due to the fact that medically sound and accepted PM & R protocols were utilized in the care of this patient and indeed were medically necessary."

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)
2-25-05 – 10-19-05	CPT code 97150 (\$20.78 X 26 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$540.28
2-25-05 – 10-19-05	CPT code 97140 (\$31.79 X 2 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$63.58
2-25-05 – 10-19-05	CPT code 97110	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	This service has been withdrawn by the requestor.
	Grand total		\$603.86

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 \$603.86.

The Division has determined that dates of service 10-17-05, 10-19-05 and 10-21-05 were not properly submitted to the insurance carrier for reconsideration per Rule 133.304. Those dates of service will not be part of this review.

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 2-24-05 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.

CPT code 97140 on 2-25-05 and 3-3-05 was denied by the carrier as "97-payment is included in the allowance for another service/procedure and "434-the value of this procedure is included in the value of the mutual exclusive procedure." Per the 2002 MFG CPT code 97140 is considered by Medicare to be a "mutually exclusive procedure of CPT codes 97012 and 97150 (which were billed on these dates of service). A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be considered justifiable if a modifier is used appropriately." No modifier was used by the requestor. Recommend no reimbursement.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.304, 133.308 and Rule 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 reimbursement in the amount of \$603.86. 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

4-18-06

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.



PROFESSIONAL ASSOCIATES

NOTICE OF INDEPENDENT REVIEW

NAME OF PATIENT:
IRO CASE NUMBER: M5-06-1028-01
NAME OF REQUESTOR: JCMLR
NAME OF PROVIDER: Thimios Partalas, D.C.
REVIEWED BY: Licensed by the Texas State Board of Chiropractic Examiners
IRO CERTIFICATION NO: IRO 5288
DATE OF REPORT: 04/04/06

Dear JCMLR:

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:

Evaluations with Thimios Partalas, D.C. dated 02/02/05, 03/04/05, 03/28/05, 05/23/05, 09/21/05, and 01/09/06
Physical therapy with Dr. Partalas dated 02/03/05, 02/08/05, 02/09/05, 02/15/05, 02/16/05, 02/18/05, 02/21/05, 02/23/05, 02/25/05, 02/28/05, 03/03/05, 04/15/05, 04/19/05, 04/20/05, 04/22/05, 04/25/05, 04/26/05, 04/29/05, 05/02/05, 05/09/05, 05/11/05, 05/13/05, 05/16/05, 09/23/05, 09/27/05, 09/28/05, 10/01/05, 10/03/05, 10/05/05, 10/07/05, 10/12/05, 10/14/05, 10/16/05, 10/17/05, and 10/21/05

Range of motion and grip strength testing performed with an unknown provider (the signature was illegible) on 02/09/05, 02/23/05, 04/20/05, 05/11/05, 09/21/05, 10/05/05, and 10/19/05

An MRI of the lumbar spine interpreted by Carlos Bazan, M.D. dated 03/09/05

An EMG/NCV study interpreted by Robert C. Lowry, M.D. dated 03/14/05

Evaluations with Jerjis J. Denno, M.D. dated 03/21/05, 06/21/05, 08/16/05, 09/16/05, 12/14/05, and 02/13/06
Functional Capacity Evaluations (FCEs) with Spiro Ioannidis, D.C. dated 03/29/05 and 05/19/05
Evaluations with Dmitriy Buyanov, M.D. dated 03/30/05, 04/27/05, and 05/27/05
Procedure notes from Dr. Buyanov dated 04/14/05, 05/12/05, and 06/06/05
A behavioral medicine evaluation with Melissa Brown, M.S., L.P.C.-I. and Phil Bohart, C.R.C., L.P.C. dated 05/25/05
A Designated Doctor Evaluation with Paul Bailey, M.D. dated 06/14/05
An operative report from Dr. Denno dated 08/03/05
Evaluations with Brian T. Rose, M.D. and Dr. Denno dated 12/02/05 and 01/16/06
An MRI of the lumbar spine interpreted by Gregory Godwin, M.D. dated 12/14/05
A letter of dispute from LaTreace E. Giles, R.N. at Texas Mutual Insurance Company dated 03/14/06

Clinical History Summarized:

Physical therapy was performed with Dr. Partalas from 02/03/05 through 10/21/05 for a total of 35 sessions. An MRI of the lumbar spine interpreted by Dr. Bazan on 03/09/05 revealed a disc extrusion at L4-L5 that compressed the right L5 nerve root and a disc protrusion at L5-S1 likely encroaching upon the left L5 nerve root and bilateral neuroforaminal narrowing at L5-S1. An EMG/NCV study interpreted by Dr. Lowry on 03/14/05 revealed evidence of chronic bilateral L5 and S1 lumbar radiculopathy. An FCE with Dr. Ioannidis on 03/29/05 determined the patient could function in the light medium physical demand level. Lumbar ESIs were performed by Dr. Buyanov on 04/14/05, 05/12/05, and 06/06/05. Another FCE with Dr. Ioannidis on 05/19/05 determined the patient was functioning at the medium physical demand level. On 06/14/05, Dr. Bailey placed the patient at Maximum Medical Improvement (MMI) at that time with a 10% whole person impairment rating. On 06/21/05, Dr. Denno recommended surgery, which was performed on 08/03/05. On 09/21/05, Dr. Partalas recommended postoperative physical therapy, a new FCE, and a dispute of MMI since surgery was performed. The MRI interpreted by Dr. Godwin on 12/14/05 revealed disc desiccation at L1-L2 and L5-S1, disc bulging and desiccation at L3-L4, and degenerative changes at L4-L5 with disc bulging, protrusion, and stenosis. On 12/14/05, Dr. Denno recommended a right L5 nerve root block. On 01/09/06, Dr. Partalas recommended nerve block and continuation of a work hardening program. On 03/14/06, Ms. Giles from Texas Mutual Insurance Company provided a letter regarding a dispute of additional reimbursement for physical therapy.

Disputed Services:

Therapeutic exercises (97110), therapeutic activities (97150), and manual therapy technique (97140) from 02/25/05 through 10/14/05

Decision:

I agree with the requestor. The therapeutic exercises, therapeutic activities, and manual therapy techniques from 02/25/05 through 10/14/05 were reasonable and medically necessary.

Rationale/Basis for Decision:

According to the medical records provided for my review, the patient injured his low back on _____. He began treatment on 02/02/05, which included therapeutic exercises, therapeutic activities, and manual therapy. The treatment dates in question are from 02/25/05 through 10/14/05. According to the North American Spine Society Phase III Clinical Guidelines for Multidisciplinary Spine Care Specialists, 2003, the types of treatments that are clinically indicated in the initial and secondary phases of care include manual therapy and therapeutic exercises. The guidelines also state the initial and secondary phases of care can last up to 16 weeks from the date of injury. The medical records show the treatments from 02/25/05 through 05/18/05 fall within the accepted guidelines as stated above. The patient had surgery to the lumbar spine on 08/03/05, which included a hemilaminotomy of L4-L5, decompression of the right L5 nerve root, and discectomy of L4-L5 on the right. The patient began postoperative rehabilitation on 09/25/05. According to the Official Disability Guidelines, 2005, post surgical rehabilitation of a lumbar discectomy is 16 weeks over eight weeks. The postoperative treatments that are in question from 09/25/05 to 10/14/05 fall within the Official Disability Guidelines acceptable number of office visits.

In short, the treatments from 02/25/05 through 10/14/05 were medically necessary to treatment the patient and fall within the previously stated acceptable guidelines for treatment of the lumbar spine, both pre and post surgical.

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 04/04/06 from the office of Professional Associates.

Sincerely,

Lisa Christian
Secretary/General Counsel