



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.: M5-06-1186-01
Southeast Health Services P. O. Box 453062 Garland, Texas 75045	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
TML Intergovernmental Risk Pool, 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, "The musculoskeletal policy allows 16 sessions. The treatment rendered was within these guidelines."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response. Position summary states, "The carrier challenges whether the charges are consistent with applicable fee guidelines. The documentation provided does not establish medical necessity."

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)
3-3-05 – 7-1-05	CPT code 99211 (\$28.28 X 21 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$593.88
3-3-05 – 7-1-05	CPT code 97140 (\$34.16 X 20 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$683.20
3-3-05 – 7-1-05	CPT code 97110 - up to 2 units per DOS (\$36.00< MAR X 40 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,440.00
3-3-05 – 7-1-05	CPT codes 97110 (more than 2 units per DOS), 97018, 99214, 99070, 97530	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
			\$2,717.08

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 \$2,717.08.

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 3-31-06 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.

CPT code 97018 on 3-3-05, 3-9-05, 3-16-05, 3-23-05, 3-24-05, 3-25-05, 4-1-05 and 6-17-05 was denied by the carrier as "charge included in another charge or service." CPT 97018 code is considered by Medicare to be a component procedure of CPT code 97140 which was billed on this date 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. The Requestor did use a modifier appropriately. Recommend reimbursement of \$64.08 (\$8.01<MAR X 8 DOS).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 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 \$2,781.16. 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, Medical Dispute Officer

5-22-06

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.

May 8, 2006

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

Patient:
DWC #:
MDR Tracking #: M5-06-1186-01
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 Doctor of Chiropractic. 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

Based on the records that were received, Mr. ___ was working for the City of Mesquite when he was injured in a work related accident on ____. The patient was working as a member of a team using a trash compactor when it accidentally started and partially crushed and lacerated the patient's right hand. He has undergone various treatment methods and physical medicine procedures and additionally has had surgery to the right hand. A second surgery to the right hand was performed in January of 2005. The care in dispute is the post-operative rehabilitative care following the second surgery.

RECORDS REVIEWED

Numerous treatment notes, diagnostic tests, evaluations, and other documentation were reviewed. Records included but were not limited to the following:

- Medical Dispute Resolution paperwork
- Numerous EOB's
- Multiple TWCC forms
- Letter of Medical Necessity from Dr. Weddle
- Michael ___ Exhibits from Dr. Weddle
- Treatment records
- Letter from Flahive, Ogden & Latson
- Designated Doctor report from Dr. Fowler
- Report from Sierra Medical Services

Report from Dr. Tsourmas
Report from Dr. Harwood
Report from Dr. Leong

DISPUTED SERVICES

The services under dispute include 97018 Paraffin bath, 99211/99214 Office visits, 97140-59 Manual therapy, 97110 Therapeutic exercises, 97530 Therapeutic activities and 99070 supplies/materials from 3/3/05 through 7/1/05.

DECISION

The reviewer agrees with the previous adverse decision regarding 97018 paraffin bath, 99214 office visits, 99070 supplies/materials and 97530 therapeutic activities for each date of service under review.

The reviewer disagrees with the previous adverse decision regarding 99211 office visits and manual therapy 97140.

The reviewer disagrees with the previous adverse decision regarding therapeutic exercises 97110 for up to two units for each date of service under review. The reviewer agrees with the previous adverse decision regarding therapeutic exercises 97110 for more than two units for any date of service under review. In other words, up to two units of 97110 for each date of service under review should be approved.

BASIS FOR THE DECISION

The basis for the determination is based upon the Medical Disability Advisor, Evidenced Based Medical Guidelines including references to Bednar, M., and T. Light. "Hand Surgery." Current Diagnosis and Treatment in Orthopedics. Skinner, J.B., and Harry B. Skinner, eds. Norwalk: Appleton & Lange, 1995. 468-479.; Hunter, James, et al. Rehabilitation of The Hand: Surgery and Therapy, 3rd ed. St. Louis: The C.V. Mosby Company, 1990.; Stanley, Barbara, and Susan Tribuzi. Concepts in Hand Rehabilitation. Philadelphia: F.A. Davis Company, 1992. 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. Considering the extent of Mr. ___'s injuries and the fact that he had to undergo two surgeries for correction, rehabilitation would be medically necessary for the services that were approved. The documentation does not support a level 99214 office visit.

There are several notations in the carrier's records that Mr. ___'s condition may have been a pre-existing condition. Although this creates a difficult situation to determine medical necessity for the care in question, the issue is the medical necessity of the post-operative rehabilitative care and not the compensability issues of the case. It should also be noted that although the services rendered are years after the injury date, which would normally exceed the timeframe required for treatment of this type of injury, the patient underwent a secondary surgery in January of 2005 for his condition. In regards to treatment of the hand according to the MDA, "recovery times are variable. Any postoperative complications will increase length of disability".

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 5th day of May 2006

Signature of Specialty IRO Representative:

Name of Specialty IRO Representative: Wendy Perelli