



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

<b>Type of Requestor:</b> ( X ) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address: Summit Rehabilitation Centers 2420 E Randol Mill Road Arlington, Texas 76011	MDR Tracking No.: M5-06-1195-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: American Zurich Insurance Company Rep Box # 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

#### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60 dispute  
POSITION SUMMARY: Per the table of disputed services "necessary".

#### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60  
POSITION SUMMARY: "Carrier challenges whether the charges are consistent with applicable fee guidelines. The carrier asserts that it has paid according to applicable fee guidelines. All reductions of the disputed charges were appropriately made. Further, the documentation provided does not establish medical necessity".

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
06-02-05 to 06-15-05	97110 (4 units @ \$144.56 X 5 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$722.80
	97140 (1 unit @ \$34.16 X 5 DOS)		\$170.80
	99213 (\$68.31 X 5 DOS)		\$341.55
	G0283 (1 unit @ \$14.65 X 5 DOS)		\$73.25
08-29-05	97750-FC (12 units @ \$38.65)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$463.80
06-06-05	95851 and 96004	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
<b>TOTAL</b>			<b>\$1,772.20</b>

#### 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 **prevailed** on the **majority** of disputed medical necessity issues.

Based on review of the disputed issues within the request, the Medical Review 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 05-11-06, 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 97750-FC (12 units) date of service 07-08-05 denied with denial code "W1:Z8" (a procedure has been billed on the same date, and on the same site, as a more extensive procedure. Since the extensive procedure has an increased level of complexity, a charge for the less extensive procedure is not appropriate). Per the 2002 Medical Fee Guideline code 97750 is considered to be a component procedure of code 96004 billed on the date of service in dispute. 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 billed with a modifier to differentiate between the services provided. Reimbursement is recommended in the amount of **\$463.80**.

CPT code 95831 date of service 07-18-05 denied with denial code "W1:Z4" (a partial procedure code has been billed. The services described by this code are part of a complete or total procedure). Per the 2002 Medical Fee Guideline CPT code 95831 is considered to be a component procedure of code 95833 and 99213 billed on the date of service in dispute. There are no circumstances in which a modifier would be appropriate. The services represented by the code combination will not be paid separately, therefore no reimbursement is recommended.

CPT code 95851 date of service 07-18-05 denied with denial code "W1:Z6" (while a separate procedure can be performed independently, the services are generally included in a more comprehensive procedure, and may not be reported when a related, more comprehensive, service is performed. Per the 2002 Medical Fee Guideline CPT code 95851 is considered to be a component procedure of code 95833, 95831 and 99213 billed on the date of service in dispute. There are no circumstances in which a modifier would be appropriate. CPT code 95851 per the 2002 Medical Fee Guideline is also considered to be a component procedure of code 97140 billed on the date of service in dispute. 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 not bill with a modifier. No reimbursement is recommended.

CPT code 99213 date of service 09-12-05 denied with denial code "W1:Z8" (a procedure has been billed on the same date, and on the same site, as a more extensive procedure. Since the extensive procedure has an increased level of complexity, a charge for the less extensive procedure is not appropriate). Per the 2002 Medical Fee Guideline CPT code 99213 is considered to be a component procedure of code 99455 billed on the date of service in dispute. There are no circumstances in which a modifier would be appropriate. The services represented by the code combination will not be paid separately, therefore no reimbursement is recommended.

CPT code 99213 date of service 11-08-05 denied with denial code "201" (two office visits were billed on the same day). Per Rule 133.307(g)(3)(A-F) the Requestor submitted documentation verifying that only one visit was performed and per the CMS 1500 only one service for CPT code 99213 was billed. Reimbursement is recommended in the amount of **\$68.31**.

#### **PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. 133.308, 134.202 and 133.307(g)(3)(A-F)

**PART VII: DIVISION DECISION AND ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the requestor is entitled to reimbursement in the amount of \$2,304.31. In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee (\$460.00). 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.

Ordered by:

05-24-06

\_\_\_\_\_  
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.**



## CompPartners Final Report ACCREDITED EXTERNAL REVIEW

CompPartners Peer Review Network  
Physician Review Recommendation  
Prepared for TDI/DWC

**Claimant Name:** \_\_\_\_\_  
**Texas IRO # :** \_\_\_\_\_  
**MDR #:** M5-06-1195-01  
**Social Security #:** \_\_\_\_\_  
**Treating Provider:** Marivel Subia, DC  
**Review:** Chart  
**State:** TX  
**Date Completed:** 4/28/06  
**Date Amended:** 5/9/06

### Review Data:

- Notification of IRO Assignment dated 4/4/06, 1 page.
- Receipt of Request dated 4/4/06, 1 page
- Medical Dispute Resolution Request/ Response dated 3/6/06, 2 pages.
- List of Treating Providers (date unspecified), 1 page.
- Table of Disputed Services dated 11/8/05, 9/12/05, 8/29/05, 7/18/05, 7/8/05, 6/15/05, 6/9/05, 6/7/05, 6/6/05, 6/2/05, 2 pages.
- Explanation of Benefits dated 6/9/05, 6/7/05, 6/6/05, 6/2/05, 3 pages.
- Doctors Position Statement for IRO Regarding Medical Necessity Denial dated 4/10/06, 3 pages.
- Disability Guidelines (date unspecified), 1 page.
- Office Visit dated 8/31/05, 8/3/05, 7/6/05, 5/23/05, 5/9/05, 4/26/05, 4/25/05, 4/11/05, 16 pages.
- Texas Workers' Compensation Work Status Report dated 5/4/05, 1 page.
- Operative Report dated 4/4/05, 3/10/05, 3 pages.
- Report of Medical Evaluation dated 8/30/05, 3 pages.
- Review of Medical History and Physical Examination dated 8/30/05, 2 pages.
- Authorization Notice dated 7/26/05, 1 page.
- Physical Examination/ Neurological Evaluation dated 8/29/05, 7/8/05, 40 pages.
- SOAP Notes dated 11/8/05, 9/12/05, 8/29/05, 7/21/05, 7/18/05, 7/8/05, 6/15/05, 6/9/05, 6/7/05, 6/6/05, 6/2/05, 29 pages.
- Range of Motion Examination dated 7/18/05, 6/6/05, 16 pages.
- Legal Letter dated 4/12/06, 3/27/06, 4 pages.
- Examination dated 4/26/05, 7 pages.

**Reason for Assignment by TDI/DWC:** Determine the appropriateness of the previously denied request for:

1. Therapeutic exercises (97110).
2. Manual therapy technique (97140).
3. Office visit (99213).
4. Electrical stimulation (G0283).
5. Range of motion (ROM) (95851).
6. Physician review and interpretation of comprehensive computer based motion analysis (96004).
7. Functional capacity evaluation (FCE) (97750-FC)

**Dates of service 6/2/05 to 11/8/05.**

### **Determination: PARTIAL**

**REVERSED** - Therapeutic exercises (97110), manual therapy technique (97140), office visit (99213), and electrical stimulation (G0283), for dates of service 6/2/05 through 6/15/05.

**REVERSED** - Functional capacity evaluation (FCE) (97750-FC), dated 8/29/05.

UPHELD - Range of motion (ROM) (95851) dated 6/6/05, and physician review and interpretation of comprehensive computer based motion analysis (96004) dated 6/6/05.

**Rationale:**

**Patient's age:**

**Gender:**

**Date of Injury:** \_\_\_\_

**Mechanism of Injury:** In an attempt to break a fall, the claimant grabbed an iron bar and struck his left wrist, resulting in fracture of his left hand and wrist.

**Diagnoses:** Closed fracture of left carpal bone, unspecified; multiple closed fractures of left hand bones, and torn ligaments of left hand/wrist; status post ORIF left hand/wrist, fractures with repair of TFCC.

The claimant is a 47-year-old male who sustained a work injury on \_\_\_\_\_. The injury occurred when the claimant was attempting to restrain himself from falling when he struck his left hand on a metal bar. As a result, the claimant fractured his left hand and wrist and tore the scaphulolunate ligament and the triangular fibro-cartilage complex. On 11/4/2004, the claimant underwent surgical repair for internal derangement, under the direction of Dr. Ippolito. On 4/4/2005, a second surgical procedure was performed by Dr. Ippolito, consisting of fusion of the left wrist carpal bones with the removal of the scaphoid bone. On 4/26/2005, the claimant underwent a Required Medical Examination (RME) with Dr. Kern. At the time of the examination, the claimant complained of left wrist pain, rated at an intensity level of 8 out of 10 on the visual analogue scale (VAS). Dr. Kern opined that "the examinee needs an aggressive rehabilitation program three times a week in conjunction with home exercise under the direction of his operating surgeon, for at least the next two months with a re-evaluation at that time as to the future treatment needs. It is probable that an active exercise program for six to nine months will be required in order to restore the examinee to a reasonable functional capacity. A good part of this could be a home exercise and personal responsibility, but only after the initial two months have been completed." The claimant continued to follow-up with Dr. Ippolito on a regular basis. A review of the SOAP notes, beginning 4/11/2005, revealed that the claimant responded well to the surgery. According to the submitted documentation, the claimant received a total of 19 post surgical rehabilitation treatments at Summit Rehabilitation Center from 5/19/2005 through 6/15/2005. The 7/6/2005 note from Dr. Ippolito, indicated that "aggressive PT/OT therapy is recommended." On 7/8/2005, the claimant underwent a functional capacity evaluation (FCE). The results were that the claimant was able to function at a light physical demand level(PDL). The claimant's job, however, required a heavy physical demand level (PDL). A request for a work conditioning program was submitted. On 7/26/2005, 15 sessions of work conditioning were authorized. Separate upper extremity range of motion and isometric muscle testing was performed on 6/6/2005 and 7/18/2005. Following the initial course of work conditioning, a follow-up functional capacity evaluation was performed on 8/29/2005. This revealed the claimant had increased from a light physical demand capacity to a medium physical demand capacity. The resultant recommendation was for enrollment in a chronic pain management program. The 8/3/2005 note from Dr. Ippolito, indicated that "the patient is to continue with current treatment." On 8/30/2005, the claimant was evaluated by Dr. Williams at the request of Texas Workers' Compensation Commission. Dr. Williams indicated that, at that time, the claimant had not yet reached maximum medical improvement (MMI). Dr. Williams opined that "pending his orthopedic hand surgeon's evaluation, if he does not need to perform any other surgery and the claimant has attained maximum benefit from the work conditioning and work hardening programs, than I think he is at MMI and is ready to be evaluated. If he does require more surgery to remove the plate, then the claimant would not be at MMI." The carrier had objected to treatments for dates of service in 6/2/2005 through 11/8/2005. The purpose of this review is to determine the medical necessity for these disputed dates of service. The carrier's position was that "Dr. Jack Kern indicated in April 2005 that the claimant would need additional treatment, but after two more months, would be able to participate in a home exercise program. The provider cannot establish the necessity of the treatment in dispute." The rationale is that the RME doctor, Dr. Kern, indicated that only two months of provider-driven rehabilitation would be necessary and any subsequent treatment would be in the context of a home-based exercise program. This is a misrepresentation of Dr. Kern's statement. In fact, what Dr. Kern stated was that an aggressive rehabilitation program three times a week in conjunction with a home exercise program, under the direction of his operating surgeon, was needed "for at least" the next two months, with a re-evaluation as to future treatment needs. It is probable that an active exercise program for six to nine months will be required in order to restore the examinee to a reasonable functional capacity. A "good part" of this could be a home exercise program and personal responsibility, but only after the initial two months have been completed. The statement "for at least" did not limit the treatment to only two months. Moreover, Dr. Kern indicated that "a good part" of the subsequent treatment could be within a home exercise program. This does not imply that the treatment would only be reasonable in a home exercise program but at least a good part of it would be. Therefore, the carrier's rationale that only two months of rehabilitation followed by only a home exercise program mischaracterizes the facts. With that said, the treatment rendered to this claimant for the dates of service from 6/2/2005 through 6/15/2005 clearly falls within the two-month time period noted by Dr. Kern. These treatments were consistent with the recommendations by Dr. Kern and the *Official Disability Guidelines* (ODG). Therefore, the treatments rendered to this claimant from 6/2/2005 through 6/15/2005, including

therapeutic exercises, 97110, myofascial release, 97140, electrical stimulation, G0283 and an E/M office visits, 99213 were appropriate. The separate range of motion test, 95851, dated 6/6/2005 was not appropriate. Range of motion testing would be a component of the E/M code and thus a separate billing was not necessary. Likewise, the Physician Review and interpretation of comprehensive computer based motion analysis, 96004 dated 6/6/05, was not medically necessary, as this was also a component of the 99213 E/M code. The claimant's surgeon, Dr. Ippolito, evaluated the claimant on 7/8/2005, and noted that an aggressive PT/OT program would be appropriate. Following the course of post surgical rehabilitation, quantification of the claimant's functional status using a functional capacity evaluation (FCE) on 8/29/05 was appropriate. A review of the SOAP notes corresponding to the dates of service from 6/2/2005 through 6/15/2005 suggests that the claimant's condition had reached a plateau. Thus, it would appear that the claimant had reached maximum therapeutic benefit from the post surgical rehabilitation program. A functional capacity evaluation (FCE) is appropriate to determine the claimant's functional status and determine if he is ready to return to work. The Functional Capacity Evaluation indicated that the claimant was able to function at a light physical demand level (PDL), which was well below his job required PDL of heavy. The carrier authorized 15 sessions of work conditioning corresponding to the dates of service from 7/26/2005 through 8/26/2005. This appears to be an appropriate course of action. Following the initial course of work conditioning, a subsequent functional capacity evaluation (FCE), dated 8/29/2005, was appropriate to quantify the claimant's improvement and document his response to the return to work program. Therefore, the functional capacity evaluation (FCE), dated 8/29/2005, was appropriate.

**Criteria/Guidelines utilized:** TDI/DWC Rules and Regulations.  
The Official Disability Guidelines, 11<sup>th</sup> Edition, 2006, pg. 184.

**Physician Reviewers Specialty:** Chiropractor

**Physician Reviewers Qualifications:** Texas Licensed D.C. and is also currently listed on the TDI/DWC ADL list.

**CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist 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 the decision before the referral to CompPartners, Inc.**

#### 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.