



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.: M5-06-1224-01
Horizon Health % Bose Consulting, L. L. C. P. O. Box 550496 Houston, Texas 77255	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
Liberty Insurance Corp, Box 28	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 treatment provided for the claimant was medically reasonable and necessary."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response. Position summary states, "Denied as not medically necessary per peer review."

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)
8-22-05 – 11-4-05	CPT code 97110 – up to 3 units per visit (\$107.58 X 27 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2,904.66
8-22-05 – 11-4-05	CPT code 97112 (\$37.77 X 27 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,019.79
8-22-05 – 11-4-05	CPT code 97110 (more than 3 units per visit), 99212, 97140	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
			\$3,924.45

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 not prevail on the majority of the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$3,924.45.

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 4-11-06 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.

The Requestor billed code 99455-WP-V3 on 10-28-05 for \$417.00. Neither the carrier nor the requestor provided EOB's per rule 133.307(e)(3)(B). Per Rule 134.202 (e)(6)(C)(i)(I-II), "An examining doctor who is the treating doctor shall bill using the 'Work related or medical disability examination by the treating physician...Reimbursement shall be the applicable established patient office visit level associated with the exam. Modifiers 'V1', 'V2', 'V3', 'V4', or 'V5' shall be added to the CPT code to correspond with the last digit of the applicable office visit." The requestor did not provide this report to support delivery of services per Rule 133.307(g)(3). The Division is unable to calculate the correct reimbursement. Recommend no reimbursement.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.307(e)(3)(B), 133.307(g)(3), 133.308, 134.202(c)(1), 134.202 (e)(6)(C)(i)(I-II).

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 Division has determined that the requestor is not entitled to a refund of the paid IRO fee. The Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute in the amount of \$3,924.45. 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, Dispute Resolution Officer

5-12-06

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 4, 2006

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

Patient:
DWC #:
MDR Tracking #: M5-06-1224-01
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 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

___ was injured on ___ while employed by UPS. The injury occurred when he slipped stepping out of a vehicle causing him to hyperextend the right knee and injure his lumbar spine. He measures 5' 10" and weighs 234 lbs. He has high blood pressure and reportedly had another injury in ___ to the right knee. He presented to the company doctor and was not satisfied with his progress. He changed treating doctors to Carrie Schwartz, DC. He had a right knee arthroscopy, bilateral meniscectomy, ACL repair, patellar and medial and lateral femoral chondral arthroplasty and cortisone injection and material on 7/14/05. He underwent post-surgical rehabilitation and was sent to modified duty on 8/9/04. The patient returned to work on 10/10/05 without restrictions. He was given a 9% WP impairment.

RECORDS REVIEWED

Records were received and reviewed from the requestor and respondent. Records from the respondent include the following: 4/13/06 letter from S Anderson, 9/29/05 review by T. Sato, DC, 11/21/05 review by T. Sato, DC, Initial Medical History by TIRR rehab, FCE of 10/19/05, SOAP notes 07/26/05 through 11/4/05 by Horizon Health, TWCC 69 and report of 10/29/05, various TWCC 73's, TWCC 49, US Healthworks rehab evaluation, 7/14/05 operative report, US Healthworks (USH) daily therapy notes 01/19/04 through 2/23/04, 2/21/05 through 3/21/05 reports by Regional Specialty Clinic, notes from Horizon Health 08/30/04 through 7/26/05, 2/23/04 post injury report by USH, 9/30/04 PRI review, 1/16/04 radiographic report of knee, shoulder and C-spine, TWCC 53 of 7/22/04, 7/7/04 PT note, DME prescriptions and 2/1/05 DME review by G. Sage, DC.

Records from the requestor include the following (in addition to the records listed above): Bose Consulting list of exhibits, Bose position statement, 8/19/04 MRI of the right knee, 5/14/05 through 01/12/06 reports by J Reuben, MD, 10/4/04 report by K Pervez, MD, notes from Horizon Health 10/31/04 through 09/20/05 and various postal receipts.

DISPUTED SERVICES

The services under dispute include therapeutic exercises (97110), office visits (99212), neuromuscular re-education (97112) and manual therapy (97140) from 8/22/05 through 11/4/05.

DECISION

The reviewer agrees with the previous adverse determination regarding the following codes on the following dates: 99212 (all dates under review), 97110 (3 units per visit) and 97140 (all dates under review).

The reviewer disagrees with the previous adverse determination regarding the following codes: 97110 (3 units per visit) and 97112 (1 unit).

BASIS FOR THE DECISION

The reviewer indicates that Medicare Payment Policies and Guidelines do not recommend an office visit to be performed on every date of service while the patient is in a rehabilitation setting. An occasional office visit could be explained by symptomatology; however, it cannot be accepted on each date of service. Secondly, the 1997 Medicare Guidelines indicate a low to moderate presenting problem, expanded problem focused history and expanded problem focused examination with straightforward medical decision-making is necessary for a 99212 CPT code. Dr. Schwartz meets the requirement for history, presenting problem and medical decision-making. Based upon the records, the examination does not meet the required six elements.

Regarding the therapeutic exercises, this patient severely injured his knee and care was apparently not appropriately provided by the company doctor. This patient had a surgical condition of the knee and was not given a surgical procedure until 6 months post injury. This likely lead to the chronic condition of this person's knee. According to Reed, "an untreated, torn ACL can over time cause muscles to atrophy and the knee joint to become dysfunctional."

The peer review by Dr. Sato indicates that no more than 12 visits were necessary as per the documentation that was available for review. He notes the patient was released for post-operative rehab on 7/26/05. The reviewer indicates that the notes indicate an increase in ROM, gait velocity and a decrease in pain through 10/31/05. The note of 11/4/05 indicates that Mr. ___'s ADL's have increased secondary to treatment. This indicates the care is medically necessary secondary to TLC §408.021.

The reviewer indicates that six units of therapeutic exercises to a knee are excessive according to the Medicare Payment and Policy Guidelines. These guidelines indicate that 30-45 minutes of rehabilitation are necessary on the average case. The reviewer does not feel this is the average case secondary to the severity of injury and the length of time of care. Therefore, an additional 15 minutes is approved per visit equating to 3 units of therapeutic exercise and 1 unit of neuromuscular re-education per visit. The neuromuscular re-education is necessary to increase the proprioceptive input to the knee leading to more stability and a reduction in the chance of injury in the future. (Gwen Jull, Mphity, FACP and Carolyn Richardson, Bphty, PhD in the February 2000 issue of JMPT, volume 23, number).

The reviewer notes that the FCE of 10/19/05 reveals he has met his job requirements and has near full range of motion in the affected extremity. This is indicative of a successful program of treatment for this patient. The reviewer wishes to note that this success could have been better documented through the use of physical performance testing or functional capacity evaluations by the treating doctor throughout the course of the active rehabilitation program.

The reviewer indicates that the constant office visits are not medically necessary, as they do not comply with Medicare Payment Policies and Guidelines. The reviewer further indicates that the manual therapies are not properly documented as per Medicare Payment Policies and Guidelines. The therapy was always performed at 8 minutes and a code/modifier -52 was not used to indicate a reduced service; therefore, medical necessity cannot be established via the documentation provided. Lastly, the procedure is not documented beyond "manual therapy (friction) 8 mins, loosens stiffness in joints." This does not indicate the location performed or the patient's response to said therapy.

REFERENCES

Medicare Payment Policies and Guidelines

Reed, P Medical Disability Advisor, 2003, Reed Group

Brotzman, S Wilk, K Clinical Orthopaedic Rehabilitation, Second Edition, 2003 Mosby, Ch 4, p 251-362.

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 4th day of May 2006

Signature of Specialty IRO Representative:

Name of Specialty IRO Representative: Wendy Perelli