



**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:	MDR Tracking No.: M5-06-1262-01
First Rio Valley Medical 620 Paredes Line Road Brownsville, TX 78521	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  TX Mutual Insurance Company, Box 54	Date of Injury:
	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, "We are officially notifying the Commission that the sender of this package is requesting a 'Medical Dispute Resolution' pursuant to 133.307."

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

Documents include the DWC 60 response.

#### 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)
4-24-03 – 6-30-03	CPT code 97110 (\$35.00 X 26 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$910.00
4-24-03 – 6-30-03	CPT code 99213 (\$48.00 X 4 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$192.00
4-24-03 – 6-30-03	CPT code 97035 (\$22.00 X 4 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$88.00
4-24-03 – 6-30-03	CPT code 97139-SS	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
			\$1,190.00

#### 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.

Review of the Table of Disputed Services revealed CPT code 97110 for date of service 5-29-03 was in dispute. However, review of the CMS 1500's and the Explanation of Benefits with an audit date of 6-20-03 revealed that the health care provider billed for CPT code 97113. Therefore, per Rule 133.307(e)(2)(B&C) CPT code 97110 on this date is not reviewable as a CMS 1500 and EOB were not submitted for this code. This service will not be a part of this dispute.

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 \$1,190.00.

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 10-3-03 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 99080-73 on 4-24-03, 5-28-03 and 7-22-03 was denied by the carrier as "TD-The DWC Status Report was not properly completed or was submitted in excess of the filing requirements Therefore, reimbursement is denied. The requestor submitted copies of the DWC-73 reports. Per 129.5(d) (3) the DWC-73 shall be submitted "on the schedule requested by the insurance carrier (carrier), its agent, or the employer requesting the report through its carrier, which shall not exceed one report every two weeks and which shall be based upon the doctor's scheduled appointments with the employee." This report did not exceed that schedule. Recommend reimbursement of \$45.00.

CPT code 97139-SS on 5-19-03, 5-21-03, 5-22-03, 5-27-03, 5-29-03, 6-9-03 and 6-12-03 was denied by the carrier as "M, RD - The reimbursement for the service rendered as been determined to be fair and reasonable based on billing and payment research and is in accordance with Labor code 412. 11(B)." Texas Labor Code 413.011 (d) and Rule 133.304 (i) (1-4) place certain requirements on the Carrier when reducing the services for which the Division has not established a maximum allowable reimbursement. The Respondent is required to develop and consistently apply a methodology to determine fair and reasonable reimbursement and explain and document the method used for the calculation. The Respondent in this case has not provided a methodology as required by the rule while the Requestor's evidence (redacted EOB's) does sufficiently justify that the Respondent's reimbursement was not fair and reasonable. The Requestor is requesting \$35.00 for seven dates of service. The Respondent reimbursed the Requestor \$173.25. Per the 1996 Medical Fee Guideline, Medicine Ground Rules (I)(A)(9)(b) and (C)(1)(m) additional reimbursement of \$71.75 is recommended.

CPT code 99214 on 7-22-03 was denied by the carrier as "N – not appropriately documented." Review of the office notes submitted for date of service 7-22-03 verifies that the documentation for this CPT code does meet the documentation criteria set forth by the 96 MFG. Per the 1996 Medical Fee Guideline, Evaluation and Management Ground Rule (IV)(c)(2) reimbursement of \$71.00 is recommended.

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

28 Texas Administrative Code Sec. 133.308 and 134.201 titled (Medical Fee Guideline for Medical Treatments and Services Provided Under the TX Worker's Compensation Act) effective April 1, 1996, 1996 MFG Medicine Ground Rule (I)(A)(9)(b) and (C)(1)(m), 1996 MFG, Evaluation and Management Ground Rule (IV)(C)(2), 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 \$1,377.75. 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

4-24-06

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.**



Specialty Independent Review Organization, Inc.

April 14, 2006

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

Patient: \_\_\_\_  
DWC #: \_\_\_\_  
MDR Tracking #: M5-06-1262-01  
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 with a specialty in Rehabilitation. 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

Mr. \_\_\_\_ was injured on \_\_\_\_ while employed by the City of Brownsville. The injury occurred when he bent over to pick up a forty-pound battery from a golf cart. The records indicate that he felt a pop in his lumbar spine followed by pain. He underwent lumbar surgeries with Madhavan Pisharodi, MD in 1999 and 2003. The patient has a complicating factor of high blood pressure and cholesterol. He presented to the office of Robert Howell, DC on 4/23/03. During this examination, ROM was decreased severely, neurological exam was normal and the orthopedic exam was equivocal to a patient with dual lumbar surgeries. The records indicate he is 5'8" and weighs 173 lbs. ROM from 4/24/03 through 5/28/03 indicates a slight increase in lumbar flexion. The patient was discharged from therapy on 7/22/03 secondary to a lack of improvement by Dr. Howell.

#### RECORDS REVIEWED

Records were received from the treating doctor/requestor. Records were requested from the respondent; however, Richard Ball of Texas Mutual indicated that he would send records "sometime next week". However, due to the statutory limitations of the review process, the review had to proceed. Records from the requestor include the following records: 3/28/06 letter from First Rio Valley, initial eval of 4/24/03 by First Rio, 5/28/03 interim assessment report by First Rio, 7/22/03 exam by Dr. Howell, SOAP notes from 5/29/03 through 6/30/03, various TWCC 73's and 4/24/03 chronological order of case management report.

#### DISPUTED SERVICES

The disputed services include therapeutic exercises 97110, spray and stretch 97139-SS, office visits 99213 and ultrasound 97035 from 4/24/03 through 06/30/03.

## DECISION

The reviewer agrees with the previous adverse determination regarding 97139-SS.

The reviewer disagrees with the previous adverse determination regarding all remaining services.

## BASIS FOR THE DECISION

The reviewer states that a passive therapy such as a spray and stretch therapy is not medically indicated, as spasm is not noted in the daily notes. However, regarding the therapeutic exercises these services are medically indicated during the period of time under review. The patient had a second lumbar surgery on 2/27/03. A minimum of eight weeks of therapeutics is indicated by the various guidelines listed below for a lumbar disc surgery. For example, the Medical Disability Advisor notes a post surgical treatment protocol of 84 days for a lumbar discectomy and 112 days for a lumbar fusion. These services were well documented and are approved.

Regarding the office visits, these are approved as they are properly documented and performed in accordance with the standards of practice of a Doctor of Chiropractic in 2003. Regarding the ultrasonic therapy, this therapy was begun on or about 5/29/03. The healing properties of ultrasound are appropriate to the post-surgical level of therapy to which this patient was prescribed.

## REFERENCES

Reed, P Medical Disability Advisor, 2003

Council of Chiropractic Physiological Therapeutics and Rehabilitation Protocols

Texas Labor Code 408.021

McFarland, C and Burkhart D Rehabilitation Protocols for Surgical and Nonsurgical Procedures-Lumbar Spine, 1999 North Atlantic Books. 57-62

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 14<sup>th</sup> day of April, 2006**

**Signature of Specialty IRO Representative:**

**Name of Specialty IRO Representative: Wendy Perelli**