



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 Dispute

PART I: GENERAL INFORMATION

| | |
|--|---------------------------------|
| Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier | |
| Requestor's Name and Address: Sports Rehabilitation Specialists 1550 W. Rosedale, Suite 522 Fort Worth, Texas 76104 | MDR Tracking No.: M5-06-1517-01 |
| | Claim No.: |
| | Injured Employee's Name: |
| Respondent's Name and Address: Texas Mutual Insurance Rep Box 54 | Date of Injury: |
| | Employer's Name: |
| | Insurance Carrier's No.: |

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60 dispute package
POSITION SUMMARY: Per the Table of Disputed Services "TWCC has no time limit no contract or law to follow LMR. Patient required 97140 to address deficits".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60
POSITION SUMMARY: "Therefore, Texas Mutual requests that the request for dispute resolution filed by SPORTS REHAB SPECIALISTS INC. be conducted under the provisions of the APA set out above".

PART IV: SUMMARY OF DISPUTE AND FINDINGS

| Date(s) of Service | CPT Code(s) or Description | Medically Necessary? | Additional Amount Due (if any) |
|--------------------|----------------------------|---|--------------------------------|
| 4-21-05 to 6-28-05 | 97140 & 97035 | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | \$0.00 |
| | | | |

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.

The Division has reviewed the enclosed IRO decision and determined that the requestor did **not** prevail on the disputed medical necessity issues.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308

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 reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

06-19-06

Authorized Signature

Typed Name

Date of Findings and Decision

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.



IMED, INC.

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NOTICE OF INDEPENDENT REVIEW

NAME OF EMPLOYEE: _____
IRO TRACKING NUMBER: M5-06-1517-01
NAME OF REQUESTOR: Sports Rehabilitation Specialists, Inc.
NAME OF CARRIER: Texas Mutual Insurance Company
TREATING DOCTOR: Joseph Gaines, M.D.
DATE OF REPORT: 06/08/06
DATE OF AMENDED REPORT: 06/14/06
IRO CERTIFICATE NUMBER: 5320

TRANSMITTED VIA FAX:

IMED, Inc. has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO).

In accordance with the requirement for TDI to randomly assign cases to IROs, TDI has assigned your case to IMED, Inc. for an independent review. The peer reviewer selected has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, the peer reviewer 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.

The independent review was performed by a matched peer with the treating physician. This case was reviewed by a D.O. physician reviewer who is Board Certified in the area of Orthopedic Surgery and is currently listed on the DWC approved doctor list.

I am the Secretary and General Counsel of IMED, Inc., 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 and the provider, the injured employee, 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. I further certify that no conflicts of interest of any nature exist between any of the aforementioned parties and any director, officer, or employee of IMED, Inc.

REVIEWER REPORT

I have reviewed the records forwarded on the above injured worker and have answered the questions submitted.

Information Provided for Review:

- Texas Mutual Insurance 04/20/05, 04/21/05, 05/03/05, 05/05/05, 05/11/05, 05/12/05, 05/16/05, 05/18/05, 05/20/05, 05/31/05, 06/02/05, 06/03/05, 06/07/05, 06/08/05, 06/09/05, 6/14/05, 06/15/05, 06/22/05, 06/28/05
- Sports Rehabilitation Specialists, Inc. 03/22/05, 03/23/05, 04/07/05, 04/13/05, 04/14/05, 04/20/05, 04/21/05, 05/03/05, 05/05/05, 05/11/05, 05/12/05, 05/16/05, 05/18/05, 05/25/05, 05/31/05, 06/02/05, 06/07/05, 06/08/05, 06/09/05, 06/14/05, 06/15/05, 06/18/05, 06/22/05, and 07/07/05

Clinical History Summarized:

This injured employee was treated at the Sports Rehabilitation Specialists, Inc. She had been injured while working for _____. She sustained an injury to the left shoulder that resulted in surgery that was performed on 01/20/05.

Sports Rehabilitation Specialists performed a shoulder evaluation at the request of Dr. Gaines on 03/22/05. The therapist reported decreased range of motion in the shoulder with painful range of motion. The physical therapy provider performed physical therapy services beginning on 04/06/05. Documentation indicates that on multiple occasions, three to four units of therapeutic exercise (97110) were combined with electrical stimulation (G0283) and manual therapy (97140). On several occasions, the insurance carrier, Texas Mutual Insurance Company, denied payment for manual therapy and ultrasound. The Explanation of Benefits noted a denial code of 57, payment denied/reduced because the payor deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or the stated supply. The requestor, Sports Rehabilitation Specialists, Inc. has requested medical dispute resolution for the unpaid services.

Disputed Services:

Items in dispute: CPT Code 97140 - Manual Therapy Technique; and CPT Code 97035 – Ultrasound; denied as medically necessary. DOS 4/21/05-6/28/05,

Decision:

After a considerable amount of research involving the Texas Administrative Code provisions, National Guidelines, and Texas Department of Insurance regulations, the determination is made that the carrier correctly denied payments. On occasions, there were more than four physical therapy codes billed. GRIA (10)a specifies that four physical therapy services may be billed on each date of service. On dates 04/21/05, 05/03/05, 05/05/05, 05/11/05, 05/12/05, 05/16/05, 06/03/05, 06/07/05, 06/08/05, 06/14/05, and 06/22/05, more than five physical therapy CPT Codes were billed.

Therefore, the carrier properly denied payment for the excessive treatments. The manual therapy and ultrasound were well documented in the clinical records. However, the provisions of GRIA (10)a do not allow for additional treatments. Therefore, the carrier properly denied payment for the excessive services.

Rationale/Basis for Decision:

The rationale for the opinion stated in this report is based on the record review, as well as the broadly accepted literature to include numerous textbooks, professional journals, nationally recognized treatment guidelines and peer consensus, to include GRIA, Texas Administrative Code and TDI regulations.

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 with IMED, Inc. is deemed to be a DWC decision and order.

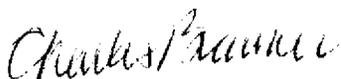
YOUR RIGHT TO REQUEST A HEARING

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, 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 thirty (30) days after the date on which the decision that is the subject of the appeal is final and appealable.

I hereby verify that a copy of this Independent Review Organization's decision was sent to the DWC via facsimile or U.S. Postal Service this 12th day of June, 2006 from the office of IMED, Inc.

Sincerely,



Charles Brawner
Secretary/General Counsel