



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

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address:	MDR Tracking No.: M5-06-1781-01
Marsha Miller, D. C. 2306 S. Buckner Blvd. Dallas, TX 75227	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
OLD REPUBLIC INSURANCE CO, BOX 02	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position Summary (Table of Disputed Services): "Post Surgical Rehab R&N."

Principle Documentation:

1. DWC-60/Table of Disputed Services/Position Summary
2. CMS-1500's
3. EOBs

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position Summary (Table of Disputed Services): "Unnecessary medical treatment based on peer review attached."

Principle Documentation:

1. DWC-60/Table of Disputed Services/Position Summary
2. 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)
6-14-05 – 7-14-05	97110 (\$36.14 x 20 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$722.80
6-14-05 – 7-14-05	G0283 (\$14.65 x 3 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$43.95
6-14-05 – 7-14-05	97140 (\$34.16 x 2 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$68.32
6-14-05 – 7-14-05	E0745	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$111.89
6-14-05 – 7-14-05	76800, 76880, 95904, 95903, 95925, 95927, 76536	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
	Total		\$946.96

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 \$946.96.

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 7-6-06 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.

Regarding CPT code 99080-73 on 7-8-05: The Respondent denied this service as "W9 - unnecessary medical treatment based on a peer review." The DWC-73 is a required report per Rule 129.5 and cannot be denied for medical necessity. Recommend reimbursement of \$15.00 according to Rule 129.5.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d) and 413.031
28 Texas Administrative Code Sec. 129.5, 133.308 and 134.1

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 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 \$961.96. The Division hereby **ORDERS** the Respondent 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 by:

Authorized Signature

Typed Name

10-27-06

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.

NOTICE OF INDEPENDENT REVIEW DECISION

July 31, 2006

Amended Letter: October 25, 2006

Program Administrator
Medical Review Division
Division of Workers Compensation
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Claim #:
Injured Worker:
MDR Tracking #: M5-06-1781-01
IRO Certificate #: IRO4326

TMF Health Quality Institute (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Division of Workers' Compensation (DWC) has assigned the above referenced case to TMF for independent review in accordance with DWC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, 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 was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and the provider, 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. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient sustained a work related injury on ___ when he was pulling bags of coins from a truck and struck the posterior back of his elbow against the side of a door on the truck. This resulted in severe blunt trauma to the posterior elbow. He had immediate pain and swelling which got worse. A CT scan of the left elbow revealed moderate degenerative changes in the elbow, a 2mm loose body in the elbow joint, and a large spur off the olecranon. Treatment has included surgery and a post-surgical rehabilitation program.

Requested Service(s)

(97110)- Therapeutic exercises, (76800) - Ultrasound spinal canal and contents
(G0283)- Electrical stimulation, (97140) - Manual therapy technique
(76880)- Ultrasound, extremity, nonvascular, B-scan and/or real time with image documentation, (E0745)- Neuromuscular stimulation, (95904)- Sensory nerve testing each nerve, (95903)- Nerve conduction study with F wave, (95925)- Short-latency somatosensory study in upper limbs, (95927)- Short-latency somatosensory study in trunk or head, (76536)- Ultrasound soft tissues of head/neck with image documentation performed from 06/14/05 to 07/14/05.

Decision

It is determined that the: (97110)- Therapeutic exercises, (G0283)- Electrical stimulation, (97140) - Manual therapy technique, (E0745)- Neuromuscular stimulation performed from 06/14/05 to 07/14/05 were medically necessary to treat this patient's condition.

It is determined that the: (76800) - Ultrasound spinal canal and contents, (76880)- Ultrasound, extremity, nonvascular, B-scan and/or real time with image documentation, (95904)- Sensory nerve testing each nerve, (95903)- Nerve conduction study with F wave, (95925)- Short-latency somatosensory study in upper limbs, (95927)- Short-latency somatosensory study in trunk or head, (76536)- Ultrasound soft tissues of head/neck with image documentation performed from 06/14/05 to 07/14/05 were not medically necessary.

Rationale/Basis for Decision

National treatment guidelines allow for post surgical rehabilitation in injuries of this nature. There is sufficient documentation to justify the use of electrical stimulation (G0283), manual therapy technique (97140), and therapeutic exercises (97110) from 06/14/05 through 07/14/05. The neuromuscular stimulation (E0745) was also medically necessary as it was used twice per day in a home setting to assist in pain control and to assist in recovery from his surgery.

The other services performed during that time frame were not necessary. The TWCC-69 indicated the patient reached maximum medical improvement (MMI) on 07/07/05. The ultrasound, extremity, nonvascular, B-scan and/or real time with image documentation (76880), sensory nerve testing each nerve (95905), nerve conduction study with F wave (95903), short-latency somatosensory study in upper limbs (95925), short-latency somatosensory study in trunk or head (95927) and ultrasound soft tissues of head/neck with image documentation (76536) were done after the patient reached MMI.

There were no exam findings documented in the records that would justify these intense additional diagnostic exams on 07/14/05. The medical progress evaluation dated 07/06/05 revealed range of motion of the left elbow to be normal. It is also revealed that the upper extremities sensation, deep tendon reflexes, and motor were ok.

Since the patient already had surgery, had completed a post-surgical rehabilitation program, and based upon the medical progress evaluation on 07/06/05 and the fact that he was placed at MMI on 07/07/05, there would be no clinical justification to perform additional diagnostic testing. Therefore, these tests were not medically necessary for the treatment of his on the job injury.

This decision by the IRO is deemed to be a DWC decision and order.

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,

Gordon B. Strom, Jr., MD
Director of Medical Assessment

Information Submitted to TMF for Review

Patient Name: _____ **Tracking #:** M5-06-1781-01

Information Submitted by Requestor:

- Letter to TMF from Buckner Back and Neck Clinic
- Initial Narrative Report from Dr. Miller
- Joint Evaluation of the Elbow
- Active Rehabilitation Notes
- SOAP Notes from Dr. Miller
- Progress notes on muscle stimulator
- Nerve Conduction Studies
- Evoked Potentials of the Upper Extremities
- Report of spinal ultrasound
- Report of the CT scan of the left elbow
- Operative Reports
- Office Notes from Dr. Elizondo
- Impairment Evaluation
- Designated Doctor Evaluation
- Worker's Compensation Review from Intracorp
- Table of Disputed Services

Information Submitted by Respondent: _____ None