



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: William Dodge, M.D. 7125 Marvin D. Love # 107 Dallas, Texas 75237	MDR Tracking No.: M5-06-1806-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Old Republic Insurance Company Rep Box # 02	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: "The carrier has denied our charges based on Medical Necessity. We submitted in for reconsideration and was again denied. We are requesting an IRO to resolve this issue. Upon request, we will submit in supporting documentation to support Medical Necessity for services rendered."

Principle Documentation:

1. DWC 60/Table of Disputed Services
2. CMS 1500's
3. Explanation of Benefits

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: The Respondent did not submit a response to MDR.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
08-30-05	97032 (1 unit @ \$20.53)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$20.53
08-30-05 and 09-07-05	97110 (1 unit @ \$36.14 X 2 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$72.28
10-18-05	99214	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$107.01
09-07-05	97140 (1 unit @ \$34.16)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$34.16
09-23-05	97004 (1 unit @ \$63.45)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$63.45
10-13-05	97750-FC (1 unit @ \$38.65 X 16 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$618.40
10-18-05, 11-29-05, 01-03-06 and 02-14-06	99080-73 (\$15.00 X 4 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$60.00
11-29-05	99213	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$68.31

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
01-03-06, 02-14-06 and 04-07-06	99213	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$68.25
09-20-05 to 10-10-05	97535, 95852, and 95851	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
09-20-05 to 01-31-06	97110, 99213 and 99080-73 (except for dates of service listed above)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
09-21-05	97530 (3 units)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
	TOTAL DUE		\$1,112.39

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.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.1 and 134.202(c)(1)
Texas Labor Code, Sec. 413.031 and 413.011 (a-d)

PART VII: DIVISION FINDINGS 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 \$1,112.39. In addition, the Division finds that the Requestor was not the prevailing party and is not entitled to a refund of the IRO fee. 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.

Order by:

10-25-06

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.

NOTICE OF INDEPENDENT REVIEW DECISION

August 18, 2006

Amended Letter: October 18, 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 #: M5-06-1806-01
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 §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 TMF physician reviewer who is board certified in Family Practice which is the same specialty as the treating physician, provides health care to injured workers, and licensed by the Texas State Board of Medical Examiners in 1975. 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 she caught her foot in a ladder mechanism causing her to fall forward landing on her left side. She landed mostly on her shoulder but also required an examination of her knee. The patient has undergone surgery, occupational, and physical therapy.

Requested Service(s)

99213, 99214-Office visits; 97032- Electrical stimulation; 97110- Therapeutic exercises; 97140- Manual therapy technique; 99080-73- DWC report; 97535- Self care management training; 97550-FC- FCE; 97530- Therapeutic activities; 97004- OT Re-evaluation; 95851- ROM; 95852- Range of motion measurement provided from 08/30/05 through 04/07/06.

Decision

It is determined that the 99213, 99214-Office visits from 08/30/05 to 09/08/05 and then once every 6 weeks, 97032- Electrical stimulation for 30 days from 08/30/05 to 09/30/05, the 97110- Therapeutic exercises and 97140- Manual therapy technique from 08/30/05 through 09/08/05, the 99080-73- DWC report at the every 6 week visit, and the 97550-FC-FCE, 97004- OT Re-evaluation from 08/30/05 through 04/07/06 were medically necessary to treat this patient's decision.

It is determined that the 99213, 99214-Office visits from 09/08/05 to 04/07/06 at more than once every 6 weeks, 97032- Electrical stimulation after 09/30/05, 97110- Therapeutic exercises and 97140- Manual therapy technique after 09/08/05 the 99080-73- DWC report more than every 6 week visit, 97535- Self care management training and the 95851- ROM; 95852- Range of motion measurement provided, and 97530- Therapeutic activities from 08/30/05 through 04/07/06 were not medically necessary.

Rationale/Basis for Decision

- Office visits, codes 99213, 99214 - The office visits from 08/30/05 through 09/08/05 should be paid in a consistent manner. Following this date, an office visit every 6 weeks would be required due to the fact that she has multiple symptoms and changing symptomatology. A bi-weekly visit would not be needed.
- Electric stimulation, code 97032 – After thirty days if there is no abatement or diminish of symptoms then this treatment modality should be stopped.

- Therapeutic exercises, code 97110 – After the 09/08/05 these exercises could be maintained on a home exercise program and the patient could be seen at a six week interval to review her progress.
- Manual therapy technique, code 97140 – The same applies for this code as stated in the above therapeutic exercise code of 97110.
- DWC report, code 99080-73 – the workers' comp report should be given by the physician at the six week period examinations.
- Self care management training, code 97535 – This patient had adequate intelligence and a home exercise program would fit her needs with supervision by her treating physician at a six week office visit.
- FCE, code 97550-FC – The FCE is medically necessary due to the fact that the information obtained from this test is very pertinent to determine if the patient is qualified to return her to work. This test indicated that she was never able to meet the minimum requirement of her job in lifting and pushing.
- Therapeutic activities, code 97530 – These activities could have been performed at home in a home exercise routine and followed by her physician at a six week interval.
- OT Re-evaluation, code 97004 – This is important due to the fact that it corresponds with the results of the FCE. The evaluation indicated that her physical activity is restricted and her ability to return to this type of job is in question.
- ROM, code 95851 – The activities that are involved in the upper extremity could have been taught and performed in a routine manner without formal therapeutic sessions. These again could have been supervised by her physician at a six week period.
- Range of motion measurement, code 95852 – The range of motion measurement during this time could have been performed by her supervising physician in his office visits.

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 #:** M5-06-1806-01

Information Submitted by Requestor:

- Letter to TMF
- Surgery Report
- Physician Records from Wol Med
- Physical Therapy Notes
- Initial Occupational Therapy Evaluation
- Occupational Therapy Notes
- Functional Capacity Evaluation
- History and Physical by Dr Diliberti

Information Submitted by Respondent:

- Table of Disputed Services
- Examiner Notes
- History and Physical by Dr Diliberti
- Physician Advisor Reviews
- Letter from attorneys
- Health Claim Forms

- **Decision letters**
- **Day surgery notes**
- **Report of MRI of shoulder**
- **Physician Records from Wol Med**
- **Office notes from Dr Taba**
- **Request for reconsideration**
- **Physical Therapy Notes**
- **Occupational therapy evaluation and notes**
- **Orthopedic History and Physical by Dr Mitchell**
- **Orthopedic Surgeon office notes**
- **Functional Capacity Evaluation**
- **Nurse's Chronological List of Submitted Records**
- **Surgery Report**
- **Office notes Dr Ippolito**
- **Office notes from Dr Dodge**