



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

Requestors Name and Address:
Southeast Health Services
P O BOX 453062
Garland, Texas 75045

MDR Tracking No.: M5-06-1815-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:

Date of Injury:

Rep Box # 42

Employer's Name:

Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

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

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 Position Summary to MDR.

Principle Documentation: No response was submitted to MDR by the Respondent.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

<u>Date(s) of Service</u>	<u>CPT Code(s) or Description</u>	<u>Medically Necessary?</u>	<u>Additional Amount Due (if any)</u>
06-15-05 to 07-11-05	97110 (1 unit @ \$36.00 X 3 units X 2 DOS) 97110 (1 unit @ \$36.00 X 2 units X 8 DOS) 97110 (1 unit @ \$36.00 X 4 units X 1 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$216.00 \$576.00 \$144.00
06-22-05 to 07-08-05	97032 (1 unit @ \$20.53 X 6 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$123.18
06-20-05 to 07-08-05	97140-59 (1 unit @ \$34.16 X 4 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$136.64
06-22-05 to 07-08-05	97016 (1 unit @ \$18.18 X 6 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$109.08
07-08-05	98940 (1 unit @ \$33.61)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$33.61
	<u>TOTAL DUE</u>		\$1,338.51

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 prevail** on the disputed medical necessity issues.

Based on review of the disputed issues within the request, Medical Dispute Resolution has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained fee issues that were not addressed by the IRO and will be reviewed by Medical Dispute Resolution.

On 08-02-06, Medical Dispute Resolution 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 97140-59 (1 unit) billed for dates of service 06-20-05 was denied by the Respondent with denial code "97A" (payment is included in the allowance for another service/procedure). Per Rule 134.202 CPT code 97140 is a component procedure of CPT code 98940 billed for the same date of service. A modifier is allowed to differentiate the services billed and separate payment for the services billed will be considered justifiable if a modifier is used appropriately. The Requestor billed with an appropriate modifier (59). Reimbursement is recommended in the amount of **\$34.16**.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.1 and 134.202
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 \$1,372.67. In addition, the Division finds that the Requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of \$460.00. 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:

09-21-06

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.

ZRC MEDICAL RESOLUTIONS

August 18, 2006

Amended August 22, 2006

Re: MDR #: M5 06 1815 01 Injured Employee: ___
DWC #: DOI: ___
IRO Cert. #: 5340 SS#: ___

TRANSMITTED VIA FAX TO:

TDI, Division of Workers' Compensation

Attention: ___

Medical Dispute Resolution

Fax: (512) 804-4868

RESPONDENT:

TREATING DOCTOR: Bryan Weddle, DC

In accordance with the requirement for DWC to randomly assign cases to IROs, DWC assigned this case to ZRC Medical Resolutions for an independent review. ZRC has performed an independent review of the medical records to determine medical necessity. In performing this review, ZRC reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the president of ZRC Medical Resolutions, 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 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 Independent Review Organization. Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a Doctor of Chiropractic who is currently listed on the DWC Approved Doctor List.

This decision by ZRC Medical Resolutions, Inc. 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, 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.

Sincerely,
Jeff Cunningham, DC
President

REVIEWER'S REPORT M5 06 1815 01

Information Provided for Review:

There are approximately 82 pages of records that were supplied including but not limited to daily notes, 7 explanation of benefits, numerous encounter forms, reports by Dr. Charles Willis, and radiographic studies.

Clinical History:

This case involves ___ who was working for the _____ as a teacher. The claimant was lifting a box of books when she injured her lower back. Physical examination was performed by Dr. Brian Weddle, and a radiological report was generated by Radiologics. She was also seen on a couple of occasions by Dr. Charles Willis.

Disputed Services:

The dates of service between 06/15/05 and 07/11/05 were denied by the carrier as unnecessary without peer review. These services include therapeutic exercises, manual therapy, electrical stimulation, vasopneumatic device and chiropractic manipulation.

Decision:

I DISAGREE WITH THE DETERMINATION MADE BY INSURANCE CARRIER IN THIS CASE.

Rationale:

The primary goal of the treating doctor in Workers' Compensation is to render medically necessary services in order to return a patient to work. This was done, as the patient was returned to work, and also an MMI date was determined along with an impairment rating.

Regarding medical necessity, the carrier denied it as unnecessary without a peer review. However, the Texas Labor Code, Section 408.021, defines medical necessity as returning the patient back to work and also curing or relieving the condition.

In accordance with the Texas Labor Code and definition of medical necessity, I find that Dr. Weddle complied. Also, the ODG Guidelines indicate that for a severe sprain, approximately 18 visits are within guidelines. In this claimant's case, there were several complicating factors including but not limited to diabetes, obesity, and radiologic findings such as spondylosis and degenerative joint disease. Based upon these factors, approximately 27 visits would be considered reasonable. This was duly noted by Dr. Weddle on a letter to the carrier on 07/29/06.

Screening Criteria/Literature:

ODG Guidelines