



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	
Requestor's Name and Address: Injury 1 Treatment Center 5445 La Sierra Drive # 204 Dallas, Texas 75231	MDR Tracking No.: M5-06-1894-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Illinois National Insurance Company Rep Box # 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: "In summary, it is our position that SRS has established an unfair and unreasonable time frame in paying for the services that were medically necessary, were preauthorized and rendered to Mr. ____."

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: "It is Carrier's contention that Injury I Treatment Center did not properly request for reconsideration in accordance with Chapter 133.304(j), 133.304(1) they have merely marked the bills **request for reconsideration** and filed them with the copy of the Medical Dispute Resolution."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
07-18-05 to 12-30-05	97545-WH-CA, 97546-WH-CA and 90880	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
TOTAL DUE			\$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.

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 08-24-06, 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 90901 (72 units total) billed for dates of service 07-18-05, 08-24-05, 09-09-05, 11-23-05, 12-13-05 and 12-30-05 was denied by the Respondent with denial code "W11" (entitlement to benefits. Not finally adjudicated. Payment is being withheld pending an investigation of the reasonable and necessity of the treatment) with the exception of date of service 09-09-05 which was denied by the Respondent with denial code "62" (payment denied/reduced for absence of, or exceeded, pre-certification/authorization. Preauthorization required but not requested). The PLN-11 filed by the Respondent stated that the compensable injury was limited to the claimant's low back and does not extend to include psych treatment. The Requestor billed with diagnoses 847.2 (lumbar sprain and strain) and 729.1 (unspecified myalgia and myositis). There were no psychiatric treatment diagnoses billed for the services in dispute. In addition, the Requestor obtained preauthorization for the services prior to the services being provided. Reimbursement is recommended per Rule 134.202 in the amount of **\$284.34 (\$47.39 X 6 DOS)**.

CPT code 90806 (5 units total) billed for dates of service 08-24-05, 09-22-05, 11-23-05, 12-13-05 and 12-30-05 were denied by the Respondent with denial code "W11" (entitlement of benefits. Not finally adjudicated. Payment is being withheld pending an investigation of the reasonable and necessity of the treatment). Date of service 12-30-05 also denied with denial code "W1" (WC State Fee schedule adjustment. Reimbursement for your resubmitted invoice has been considered. No additional monies are being paid at this time). The PLN-11 filed by the Respondent stated that the compensable injury was limited to the claimant's low back and does not extend to include psych treatment. The Requestor billed with diagnoses 847.2 (lumbar sprain and strain) and 729.1 (unspecified myalgia and myositis). There were no psychiatric treatment diagnoses billed for the services in dispute. In addition, the Requestor obtained preauthorization for the services prior to the services being provided. Reimbursement is recommended per Rule 134.202 in the amount of **\$598.75 (\$119.75 X 5 units)**.

CPT code 90806 (1 unit) billed for date of service 09-01-05 was denied by the Respondent with denial codes "R" (information received from the adjuster does not indicate that the condition/diagnosis is related to the compensable injury. If you feel that our decision is in error, please contact the claim adjuster) and "W12" (extent of injury. Reimbursement withheld – charge unrelated to compensable injury). The PLN-11 filed by the Respondent stated that the compensable injury was limited to the claimant's low back and does not extend to include psych treatment. The Requestor billed with diagnoses 847.2 (lumbar sprain and strain) and 729.1 (unspecified myalgia and myositis). There were no psychiatric treatment diagnoses billed for the service in dispute. In addition, the Requestor obtained preauthorization for the service prior to the service being provided. Reimbursement is recommended per Rule 134.202 in the amount of **\$119.75**.

CPT code 90806 (2 units) billed for dates of service 09-09-05 and 11-18-05 were denied by the Respondent with denial code "62" (payment denied/reduced for absence of, or exceeded, pre-certification/authorization. Preauthorization required but not requested). The Requestor obtained preauthorization for the services prior to the services being provided. Reimbursement is recommended per Rule 134.202 in the amount of **\$239.50 (\$119.75 X 2 units)**.

CPT code 90806 (1 unit) billed for date of service 09-15-05 was denied by the Respondent with denial code "W9" (unnecessary med treatment based on peer review. Peer review obtained by the carrier ind treatment to be medically unreasonable and/or unnecessary and documented srvc does not meet Fee guide contained w/I appli AMA CPT/HCPCS guide). The Requestor obtained preauthorization for the services prior to the services being provided. Reimbursement is recommended per Rule 134.202 in the amount of **\$119.75**.

CPT code 90806 (1 unit) billed for date of service 09-29-05 was denied by the Respondent with denial codes "62" (payment denied/reduced for absence of, or exceeded, pre-certification/authorization. Preauthorization required but not requested) and "W12" (extent of injury not finally adjudicated. Reimbursement withheld – charge unrelated to compensable injury). The PLN-11 filed by the Respondent stated that the compensable injury was limited to the claimant low back and does not extend to include psych treatment. The Requestor billed with diagnoses 847.2 (lumbar sprain and strain) and 729.1 (unspecified myalgia and myositis). There were no psychiatric treatment diagnoses billed for the service in dispute. In addition, the Requestor obtained preauthorization for the service prior to the service being provided. Reimbursement is recommended per Rule 134.202 in the amount of \$119.75.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.1, 134.202 and 134.600
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 ~~\$1,481.84~~. 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:

11-13-06

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.

MEDICAL REVIEW OF TEXAS

[IRO #5259]

10817 W. Hwy. 71
Phone: 512-288-3300

Austin, Texas 78735
FAX: 512-288-3356

NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISED 10/2/06

TDI-WC Case Number:	
MDR Tracking Number:	M5-06-1894-01
Name of Patient:	
Name of URA/Payer:	Injury One Treatment Center
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Cody Doyle, DC

September 14, 2006

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on the Division of Workers' Compensation Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely, Michael S. Lifshen, MD Medical Director

cc: Division of Workers' Compensation

DOCUMENTS REVIEWED

1. Notification of IRO Assignment, Table of Disputed Services, and Carrier Reviews
2. Functional capacity evaluations, dated 8/29/05 and 10/28/05
3. Letter of medical necessity, dated 8/3/06
4. Initial history and physical narrative from the work hardening referral physician, dated 9/7/05
5. Work hardening daily notes, interdisciplinary group therapy notes, and work hardening "daily flow sheets," multiple dates
6. Follow-up narratives from work hardening referral physician, multiple dates
7. Biofeedback therapy notes, individual psychotherapy notes, "lunch hour psychotherapeutic group notes," and psychotherapeutic group notes, multiple dates

CLINICAL HISTORY

Patient is a 30-year-old male machine operator who, on [redacted] was lifting bad tires onto a trailer; reportedly, he was also required to flip the tires over to dump the water out from the previous day's rain. He was throwing these tires over his head when he suddenly felt a pop in his back, along with a poking sensation and a tingling down his entire spine, from approximately shoulder level to his waist.

On 1/4/05, the patient had a thoracic MRI that reportedly revealed a small right paracentral disc herniation at T11-12. Soon thereafter, he was given two ESIs with minimal relief. An MRI of the claimant's spine was performed on 7/18/05 and it reportedly revealed degenerative disc disease at L5-S1. He eventually presented to a doctor of chiropractic who attempted a conservative trial of chiropractic care, including physical therapy and rehabilitation. When this produced less than desirable results, he was then referred for a work hardening program that included individual psychotherapy sessions and hypnotherapy

REQUESTED SERVICE(S)

Work hardening program (97545-WH-CA and 97546-WH-CA) and hypnotherapy (90880) for dates of service 7/18/05 through 12/20/05.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

In the preamble of the Texas Workers Compensation Commission's amendments to rule 134.600, the Commission states as follows: "Over-utilization of medical care can both endanger the health of injured workers and unnecessarily inflate system costs. Unnecessary and inappropriate health care does not benefit the injured employee or the workers' compensation system. Unnecessary treatment may place the injured

worker at medical risk, cause loss of income, and may lead to a disability mindset. Unnecessary or inappropriate treatment can cause an acute or chronic condition to develop.” In its report to the legislature, the Research and Oversight Council on Texas Workers’ Compensation explained its higher costs compared to other health care delivery systems by stating, “Additional differences between Texas workers’ compensation and Texas group health systems also widen the cost gap. These differences include...in the case of workers’ compensation, the inclusion of costly and questionable medical services (e.g., work hardening/conditioning.)” In this case, the provider’s work hardening program is just the type of questionable services of which the TWCC and the legislature spoke when expressing concern in regard to medically unnecessary treatments that may place the injured worker at medical risk, create disability mindset, and unnecessarily inflate system costs.

More importantly, the previously attempted physical medicine treatments, individual psychological and biofeedback sessions had within them the self-help strategies, coping mechanisms, exercises and modalities that were inherent in and central to the work hardening program. In other words and for all practical purposes, much of the work hardening program had already been attempted and failed. Therefore, since the patient was not likely to benefit in any meaningful way from repeating unsuccessful treatments, the work hardening program was medically unnecessary.

The records fail to substantiate that the disputed services fulfilled statutory requirements for medical necessity since the patient obtained no relief, promotion of recovery was not accomplished and there was no enhancement of the employee’s ability to return to or retain employment. Specifically, the claimant’s pain rating was “5/10” (where a “0” represented no pain, and a “10” represented the worst pain imaginable) on 09/15/05—the first date of the disputed treatment—and was a “6/10” on 11/09/05, the termination of the disputed treatment.

Also, there was no documented improvement from the 08/29/05 FCE to the 10/28/05 FCE. In fact, no inclinometry report was supplied for the examination on 10/28/05 and no other qualitative or quantitative documentation of improvement was supplied. Moreover, the 10/28/05 FCE stated that claimant was still unable to return to work.

Current Procedural Terminology (“CPT”) code 90880 on 09/15/05 is also denied since it would have been a component of the work hardening program.

Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that I have no known conflicts of interest between the 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.

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.

Chief Clerk of Proceedings
Division of Workers’ Compensation
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

Signature of IRO Employee: _____
Printed Name of IRO Employee: Cindy Mitchell