



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: La Plaza Rehab/SGB LLC 2351 W.N.W. Hwy Ste # 3100 Dallas, Texas 75220	MDR Tracking No.: M5-06-1967-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: TPCIGA for Legion Insurance Company Rep Box # 50	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: "A copy of the Texas Labor Code 413.011 was sent with the request for reconsideration which clearly states that there are not treatment guidelines being used at this time in Texas. A copy of adopted rule 134.202 was sent that clearly states that the CMS treatment guides are not to be used due to a conflict with the TWCC's rules and regulations. According to the documentation that was submitted medical necessity was established and the need for continued care was demonstrated."

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: "Since the medical records are lacking in information and the documentation failed to establish medical necessity for exceeding forty-five minutes of therapy, no additional allowance is recommended for the remainder of codes."

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)
10-31-05 to 11-30-05	97110-GP, 97530-GP-59, 97032-GP, 97116-GP and 97140-GP	<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 09-29-06, 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 97032-GP (1 unit each date of service) billed for dates of service 07-25-05, 07-27-05, 07-28-05, 09-06-05, 10-31-05, 11-02-05, 11-04-05 and 11-11-05 for a total of 8 units were per the Respondent's response submitted to MDR and EOB's denied by the Respondent with ANSI denial code "W1" (Workers Compensation State Fee Schedule adjustment). The Respondent has not made a payment. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$164.24 (\$20.53 X 8 units)**.

CPT code 97140-GP (1 unit each date of service) billed for dates of service 07-25-05, 07-27-05, 07-28-05, 09-06-05, 11-04-05 and 11-11-05 for a total of 6 units were per the Respondent's response submitted to MDR and EOB's denied by the Respondent with ANSI denial code "W1" (Workers Compensation State Fee Schedule adjustment). The Respondent has not made a payment. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$204.96 (\$34.16 X 6 units)**.

CPT code 97110-GP (1 unit each date of service) billed for dates of service 07-25-05, 07-27-05, 07-28-05, 09-09-05, 09-13-05, 09-14-05, 09-16-05, 09-26-05, 09-28-05, 09-30-05, 11-14-05, 11-16-05 and date of service 09-06-05 (2 units) for a total of 14 units were per the Respondent's response submitted to MDR and EOB's denied by the Respondent with ANSI denial code "W1" (Workers Compensation State Fee Schedule adjustment). The Respondent has not made a payment. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$505.96 (\$36.14 X 14 units)**.

CPT code 97530-GP-59 (1 unit each date of service) billed for dates of service 09-06-05, 09-09-05, 11-07-05 and dates of service billed (2 units each date of service) for dates 09-13-05, 09-14-05, 09-16-05, 09-26-05, 09-28-05 and 09-30-05 for a total of 15 units were per the Respondent's response submitted to MDR and EOB's denied by the Respondent with ANSI denial code "W1" (Workers Compensation State Fee Schedule adjustment). The Respondent has not made a payment. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$572.70 (\$38.18 X 15 units)**.

CPT code 97116-GP (2 units each date of service) billed for dates of service 10-31-05, 11-02-05, 11-07-05, 11-09-05 and dates of service (1 unit billed each date of service) for dates of service 11-04-05 and 11-11-05 for a total of 10 units were per the Respondent's response submitted to MDR and EOB's denied by the Respondent with ANSI denial code "W1" (Workers Compensation State Fee Schedule adjustment). The Respondent has not made a payment. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$317.30 (\$31.73 X 10 units)**.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.307, 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 \$1,765.16. 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:

10-23-06

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.



IMED, INC.

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NOTICE OF INDEPENDENT REVIEW

NAME OF EMPLOYEE:
IRO TRACKING NUMBER: M5-06-1967-01
NAME OF REQUESTOR: La Plaza Rehab/SGBLLC
NAME OF CARRIER: TPCIGA
DATE OF REPORT/EVALUATION: 09/03/06
DATE OF AMENDED REPORT: 10/120/06
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:

- 11/14/01, 12/07/01, 12/19/01, – John Tenny, M.D.
- 12/20/01 – Operative report, John Tenny, M.D.
- 12/27/01, 02/07/02, 02/28/02, 03/11/02, 04/08/02, 05/06/02, 06/12/02, 08/12/02, 11/11/02, 11/17/02, 02/10/03, 08/20/03, 11/06/03, 11/13/03, 11/20/03, 01/30/04, 03/29/04, 05/24/04, 06/17/04, 09/22/04, 10/06/04.
- 06/22/04 – Operative report, John Tenny, M.D.
- 07/12/04, 08/02/04, 08/11/04, 08/23/04, 09/13/04, John Tenny, M.D.
- Week of 10/11/04 through 10/15/04, weekly therapy summary, LaPlaza Rehab.
- 10/18/04 through 10/22/04, weekly therapy summary, LaPlaza Rehab.
- 10/25/04 through 10/29/04, weekly therapy summary, LaPlaza Rehab.
- 11/01/04 through 11/05/04, weekly therapy summary, LaPlaza Rehab.
- 11/08/04 through 11/12/04, weekly therapy summary, LaPlaza Rehab.
- 11/15/04 through 11/19/04, weekly therapy summary, LaPlaza Rehab.
- 11/22/04 through 11/26/04, weekly therapy summary, LaPlaza Rehab.
- 11/29/04 through 12/03/04, weekly therapy summary, LaPlaza Rehab.
- 12/06/04 through 12/10/04, weekly therapy summary, LaPlaza Rehab.
- 12/13/04 through 12/17/04, weekly therapy summary, LaPlaza Rehab.
- 12/27/04 – LaPlaza Rehab, Jerry Franz, M.D.
- 01/06/05 - Required Medical Evaluation, Charles Mitchell, M.D.
- 07/11/05 through 07/15/05, weekly therapy summary, LaPlaza Rehab.
- 07/11/05 through 01/06/06, weekly therapy summaries, LaPlaza Rehab.
- 07/27/05 – Functional Capacity Evaluation.
- 08/22/05 – Follow-up visit with Jerry Franz, M.D.
- 10/26/05 – Follow-up visit with Jerry Franz, M.D.
- 11/29/05 – Preauthorization request.
- 08/10/06 – Argus Services.

Clinical History Summarized:

The employee injured her left knee at work on ____.

The employee was treated by Dr. Roye and eventually underwent arthroscopic surgery in October, 2000. The employee indicated that her knee never improved. It was indicated that she returned to full duty work.

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The employee presented to John Tenny, M.D., on 11/14/01. X-rays revealed possible meniscus tear of the left knee. Dr. Tenny recommended an MRI scan and light duty.

The employee continued to treat with Dr. Tenny. The employee was taken to surgery by Dr. Tenny on 12/20/01. The preoperative diagnosis was tears of the medial and lateral meniscus of the left knee.

There was an operative report on 06/22/04. The preoperative diagnosis was medial compartment arthritis of the left knee.

Following surgery, the employee continued to follow-up with Dr. Tenny.

The employee entered therapy on 10/11/04 at LaPlaza Rehab with Senyon Narosod, NSPT. The employee continued with therapy at LaPlaza Rehab through 2006.

There was a Required Medical Evaluation (RME) on 01/06/05 with Dr. Charles Mitchell. Dr. Mitchell indicated that the effects of the injury had not resolved, and that the employee's diagnosis of left knee traumatic arthritis was related to the injury. Dr. Mitchell indicated that a total knee replacement was not indicated, as the employee was so young. He indicated that a more aggressive quad strengthening and hamstring strengthening program could help. Dr. Mitchell also indicated that the employee was not a surgical candidate, and that Naprosyn would be reasonable and necessary. Dr. Mitchell also indicated that a progressive physical therapy program was reasonable and necessary.

On 2/23/05, Dr. Sazy performed a total left knee replacement.

The injured employee contacted an infection, and post op therapy was postponed.

On or about July 1, 2005, Dr. Sazy cleared the employee for therapy. She followed up with La Plaza Rehab on 7/5/05 and rehab therapy was started.

The employee continued with rehabilitation.

10/26/05, there was a follow up report with Jerry Franz, M.D.

On 11/29/05, there was a preauthorization request for physical therapy services.

Disputed Services:

Items in Dispute: Therapeutic exercises (97110-GP), therapeutic activities (97530-GP-59), electrical stimulation (97032-GP), gait training 97116-GP), and manual therapy technique (97140-GP). Dates of service: 10/31/05 through 11/30/05.

Decision:

Denial upheld.

Rationale/Basis for Decision:

This claimant had four surgeries on her left knee finally culminating in a total knee arthroplasty. She was in her late 40s at the time of the surgeries. Through 3-4 years of the treatment cycle, she was working on full duty, although complaining of pain. She was taken to surgery on 02/23/05 for the final total knee arthroplasty. An infection or inflammatory process caused a delay in the initiation of postoperative therapy, which was not begun until July.

The standard of care for postoperative treatment of a total knee arthroplasty includes active physical therapy for four weeks. If there was a well documented examination and rationale for continued treatment, *ACOEM Guidelines* provide for an additional four weeks of treatment. After that time, there are no indications for further active physical therapy. After 10/01/05, there were no indications for further physical therapy, work conditioning/hardening, or other active modality treatments. This claimant should have been instructed in a home exercise program and discharged from formal physical therapy. The disputed items were not indicated on the dates cited and she should have been treated with home exercise.

The rationale for the opinion stated in this report is based on the *ACOEM Guidelines*, record review, as well as the broadly accepted literature to include numerous textbooks, professional journals, nationally recognized treatment guidelines and peer consensus.

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 6th day of September, 2006 from the office of IMED, Inc.

Sincerely,

Charles Brawner
Secretary/General Counsel