



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: Mega Rehab/Dr. Stephen Dudas 3536 CREEKSIDE CT Bedford, TX 76021-4030	MDR Tracking No.: M5-06-1988-01
	Previous MDR No.: M4-04-4450-01
	Claim No.:
Respondent's Name and Address: AMERISURE MUTUAL INSURANCE CO, Box 47	Injured Employee's Name:
	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary (Table of Disputed Services) states, "requesting reimbursement for services rendered."

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. CMS-1500's
3. EOB's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary states, "...was receiving chiropractic treatment on 10-7-02 through 04/03, which included physical therapy. This treatment was with his treating physician... At the same time he was receiving physical therapy from Mega Rehab for that same period."

Principle Documentation:

4. DWC-60/Table of Disputed Service
5. CMS-1500's
6. EOB's

PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

<u>Date(s) of Service</u>	<u>CPT Code(s) or Description</u>	<u>Medically Necessary?</u>	<u>Additional Amount Due (if any)</u>
2-19-03 – 3-17-03	97110 (\$35.00 x 23 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$805.00
2-19-03 – 3-17-03	97014	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$15.00
	Total Due	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$820.00

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 prevail on the disputed medical necessity issues. Per Rule 134.202(d)(2) the amount due the Requestor for the items denied for medical necessity is \$820.00.

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 9-14-06 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 76000-27 on 1-24-03: Per Advisory 97-01 "If a health care provider believes fluoroscopic assistance (fluoroscope) is medically necessary when performing an injection, and it is not included in the procedure, the provider shall bill the appropriate CPT code for the injection and the appropriate CPT code for the fluoroscopic assistance." Recommend reimbursement per the 1996 Medical Fee Guideline of \$88.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d) and 413.031
28 Texas Administrative Code Sec. 134.1, 133.307, 133.308
Medicine Ground Rules for the 1996 Medical Fee Guidelines
1996 Medical Fee Guidelines

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 Respondent must refund the amount of the IRO fee (\$460.00) to the Requestor within 30 days of receipt of this order. The Division has determined that the Requestor is entitled to reimbursement in the amount of \$908.00. 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.

Findings and Decision and Order by:

Medical Dispute Officer

12-01-06

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.

INDEPENDENT REVIEW INCORPORATED

October 28, 2006

Re: **MDR #:** **M5 06 1988 01** **Injured Employee:** ___
 DWC #: ___ **DOI:** ___
 IRO Cert. #: **5055** **SS#:** ___

TRANSMITTED VIA FAX TO:
TDI, Division of Workers' Compensation
Attention: ___
Medical Dispute Resolution
Fax: (512) 804-4868

RESPONDENT: **Amerisure**

REQUESTOR: **Mega Rehab**

TREATING DOCTOR: **Vaughn Brozek, DC**

In accordance with the requirement for DWC to randomly assign cases to IROs, DWC assigned this case to IRI for an independent review. IRI has performed an independent review of the medical records to determine medical necessity. In performing this review, IRI 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 office manager of Independent Review, 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 chiropractor who is board certified in pain management and is currently listed on the DWC Approved Doctor List.

This decision by Independent Review, 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
Office Manager

INDEPENDENT REVIEW INCORPORATED

REVIEWER'S REPORT M5 06 1988 01

MEDICAL INFORMATION REVIEWED:

1. DWC Assignment
2. Carrier records
3. Requestor records

BRIEF CLINICAL HISTORY:

Mr. ___ was a victim of repetitive stress injuries from lifting angle iron, concrete and other construction type of material for close to 15 years. There was no reported "specific injury", but rather an accumulation of injuries that eventually made Mr. ___ seek treatment from Dr. Vaughn Brozek. Treatment consisted of extensive passive and active therapy over a period of a year or more. During the period in dispute, the patient was receiving a significant number of spinal injections and procedures.

DISPUTED SERVICES:

97110-Therapeutic procedures; 97014-electrical stimulation from February 19, 2003 through March 17, 2003.

DECISION:

I DISAGREE WITH THE INSURANCE CARRIER'S PRIOR FINDING IN THIS CASE.

RATIONALE OR BASIS FOR DECISION:

It is true that this case extended for a very long period of time, but it is also true that the *injury* extended over 15 years of repetitive trauma. This makes it difficult, if not impossible, to control pain and increase functional behavior in a very short period of time. The patient was undergoing extremely painful injections during the time of the dispute and the treating doctor was correct in using palliative measures to control the pain as well as functional procedures to help the patient regain some form of functional ability. As a result, I believe that all of the care rendered was reasonable and necessary based on unique circumstances of this case.

SCREENING CRITERIA/STUDIES

The TCA/Mercy guides were studied, but no guideline completely covers a case with this

type of history. As a result, experience and history was the main guide on this case.