



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.: M5-06-2083-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Box 42	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, "This claim was denied 'per peer review,' please see the attached letter of medical necessity for clarification of this service."

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, "Harris and Harris represents _____ in this matter. Please direct all future correspondence...to the undersigned at Harris and Harris."

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. CMS-1500's
3. 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>
8-8-05 – 8-23-05	97110-59 (\$36.14 x 30 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,084.20
8-16-05, 8-18-05, 8-22-05, 8-23-05, 10-05-05, 10-11-05	97016 (\$18.18 x 6 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$109.08
8-22-05, 8-23-05, 8-29-05, 9-2-05, 9-6-05, 9-7-05, 9-12-05, 9-13-05, 10-06-05	97035 (\$15.59 x 9 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$140.31
9-7-05, 9-8-05	97140-59 (\$34.16 x 2 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$68.32
8-26-05	99214	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$107.01
8-9-05, 9-2-05, 10-3-05, 10-04-05, 10-17-05, 10-19-05, 10-26-05	99080-73 (\$15.00 x 7 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$105.00
8-8-05 – 10-26-05	97110-59, 99211, 99212, 97032, 97035, 98940, 98941, 97140-59, 97750-FC, 97016, 93799 (except as noted above)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00

Total Due			\$1,613.92
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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.

Dates of service 08-03-05 – 08-05-05 per Rule 133.308(e)(1) were not timely filed and are ineligible for review.

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 413.011 and 413.031

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 Division has determined that the Requestor is not entitled to a refund of the paid IRO fee. The Division has determined that the Requestor is entitled to reimbursement for the services involved in this dispute in the amount of \$1,613.92. 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

10-24-06

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 esta correspondencia, favor de llamar a 512-804-4812.



October 3, 2006

AMENDED October 19, 2006

Re: MDR #: M5 06 2083 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: James Syvrud, 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 chiropractor 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 2083 01

Information Provided for Review:

1. DWC assignment
2. Records from treating doctor
3. Records from insurer

Brief Clinical History: Patient is a 30-year-old teacher's aide for a local school district who, on ____, slipped and fell on water that was on the floor and injured her hands and right knee. After an unsuccessful trial of non-surgical care, the patient underwent right knee arthroscopy that included partial medial meniscectomy, "picking" of the posterior horn of the meniscus and abrasion chondroplasty of the medial trochlear groove and patellofemoral joint on 7/26/2005. This was followed by post-surgical rehabilitation and physical therapy.

Item(s) and Date(s) in Dispute: Therapeutic exercises (97110-59-59), office visits, levels I, II and IV (99211, 99212 and 99214, respectively), special reports (99080-73), electrical stimulation, attended (97032), ultrasound (97035), chiropractic manipulative treatment, spinal 1-2 areas and spinal 3-4 areas (98940 and 98941, respectively), manual therapy techniques (97140-59), functional capacity evaluation (97750-FC), vasopneumatic devices (97016), and unlisted cardiovascular service (93799) for dates of service 8/8/2005 through 10/26/2005.

Decision: The reviewer partially agrees with the carrier's determination.

Therapeutic exercises (97110-59) *through and including date of service 8/23/05 only*, vasopneumatic devices (97016) *for dates of service 8/16, 8/18, 8/22, 8/23, 10/5 and 10/11/05 only*, ultrasound therapy (97035) *for dates of service 8/22, 8/23, 8/29, 9/2, 9/6, 9/7, 9/12, 9/13, and 10/6/05 only*, both sessions of manual therapy techniques (dates of service 9/7/05 and 9/8/05, listed as 97140-59 for "passive stretching"), the office visit, level IV (99214) on date of service 8/26/05, and all special reports (99080-73) within the specified date range are considered reasonable and necessary.

All remaining services and procedures within those dates of service, *along with those that occurred outside the specified dates*, are denied.

Rationale/Basis for Decision: First of all, the medical records submitted adequately documented that a compensable injury occurred and that the claimant underwent a surgical procedure on 7/25/2005. Therefore, it was supported as medically necessary that the patient received passive modalities in the form of ultrasound and vasopneumatic therapy services, passive stretching, supervised exercises, and all required reports for the 10-week period.

However, in terms of the partial approvals (vasopneumatic devices and ultrasound), the medical records were completely absent for dates of service 9/19, 9/21, 9/26, 9/27 and 9/28/05. Therefore, the medical necessity was not supported. Likewise, for the dates of service where ultrasound was reported and not approved, the medical records for those dates of service failed to indicate that it was even performed on their daily treatment forms. Additionally, insofar as the vasopneumatic device services outside the dates approved, the medical records for those dates of service failed to document the objective presence of swelling about the right knee. According to a Medicare Policy Statement,¹ “The use of vasopneumatic devices may be considered reasonable and necessary for the application of pressure to an extremity for the purpose of reducing edema. Specific indications for the use of vasopneumatic devices include the reduction of edema after acute injury and lymphedema of an extremity.” In fact, the treating doctor’s reexamination on date of service 8/26/05 *failed to even mention* the presence of joint swelling anywhere in the findings. And with respect to the attended electrical stimulation (97032) services, *not a single daily note* on this patient ever indicated that this service was performed. According to the *ACA Clinical Documentation Manual*², services that are provided must be documented if performed. Since the records failed to indicate that attended electrical stimulation was *ever* performed, or that ultrasound was performed on *all* dates of services, or that swelling was present on all patient encounters where vasopneumatic was reported, these services were unsupported as medically necessary.

Regarding the chiropractic manipulations (98941 and 98940) performed on 8/24/05 9/12/05, respectfully, nothing in the daily notes for these dates of services documented anything referable to spinal complaints or objective spinal problems that would otherwise warrant and support the performance of these procedures. Furthermore, the reexamination performed by the treating doctor of chiropractic on 8/26/05 was based solely on the claimant’s right knee, and didn’t even address either spinal complaints or objective measurements. Therefore, the performance of spinal manipulation was unsupported as medically necessary.

¹ Medicare Medical Policy Bulletin Y-1S: Physical Therapy and Rehabilitation Services

² American Chiropractic Association *Clinical Documentation Manual*, American Chiropractic Foundation Press, 2005

In terms of the office visits other than the level IV service performed on 8/26/05 (99214), nothing in either the diagnosis or the daily notes supported the medical necessity of performing an Evaluation and Management (E/M) service on each and every patient encounter, separate and above what is already a part of the individual reported procedures (according to CPT³), and particularly not during the performance of an pre-determined treatment plan.

And finally, with regard to the unlisted cardiovascular service or procedure (93799), reported on date of service 10/24/05, the documentation submitted was absent anything that would support the medical necessity of this procedure. In fact, the daily record for that date failed to even mention what the specific procedure was. Therefore, its performance was not supported as medically necessary.

³ *CPT 2004: Physician's Current Procedural Terminology, Fourth Edition, Revised.* (American Medical Association, Chicago, IL 1999),