



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	
Requestors Name and Address: Summit Rehabilitation Centers 2420 E Randol Mill Rd. Arlington TX 76011	MDR Tracking No.: M5-07-0104-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: AMERICAN CASUALTY CO OF READING, BOX 47	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary states, "Provider sent a request for reconsideration. Proof that carrier received request is also included. Carrier chose not to respond within the 28 day time frame rule."

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, "The Carrier maintains the services for which payment is being sought by Summit Rehabilitation Centers were not reasonable and necessary to treat the compensable injury as outlined under Section 408.021 of the Texas Labor Code."

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

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
1-4-06 – 3-20-06	97110 (\$36.10 x 14 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$505.40
1-4-06	97530 (\$37.64 x 4 units) (global to 97140 on other dates of service)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$150.56
1-4-06 – 2-7-06	99213 (\$68.25 x 7 DOS - \$18.25 paid for 2-7-06)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$459.50
1-4-06 1-11-06	G0283 (\$14.64 x 5 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$73.20
1-5-06 – 1-11-06	97018 (global to 97140)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$0.00
1-5-06 - 1-13-06	97112 (\$37.61 x 5 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$188.05
1-5-06 – 1-13-06	97140 (\$33.64 x 5 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	168.20
1-9-06	95852 (global to 99213)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$0.00
1-9-06 – 3-6-06	96004 (\$155.11 + \$150.95)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$306.06
1-16-06	97750-FC (\$38.61 x 8 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$308.88
			\$2,159.85

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 (c)(1) the amount due the Requestor for the items denied for medical necessity is \$2,159.85.

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 10-24-06 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.

CPT code 99354 on 3-30-06 was denied by the carrier as "16 – not appropriately documented." The Requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F) and Rule 133.301(c). Reimbursement of \$123.95<MAR per Rule 134.202(d)(2) is recommended.

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, 134.202, 133.308

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 \$2,283.80. 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

1-9-06

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.

NOTICE OF INDEPENDENT REVIEW DECISION

December 1, 2006

Medical Review Division Division of Workers Compensation
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Claim #:
Injured Worker: _____
MDR Tracking #: M5-07-0104-01
IRO Certificate #: IRO4326

TMF Health Quality Institute (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Division of Workers' Compensation (DWC) has assigned the above referenced case to TMF for independent review in accordance with DWC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, 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 was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and the provider, 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. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient sustained a work related injury on _____ resulting in a crush injury to the fingers of the right hand. He has undergone chiropractic care, medication, therapy, surgery, post-operative rehabilitation, and participation in a work-hardening program.

Requested Service(s)

97110-Therapeutic exercises; 97530-Therapeutic activities; 99213-Office Visits; G0283-Electrical Stimulation; 97018-Paraffin bath; 97112-Neuromuscular re-education; 97140-Manual therapy; 95852-Neuromuscular Proc Evaluation hand; 96004-Phys review & interpretation; 97750-FC, Functional capacity all provided from 01/04/06 to 01/23/06.

Decision

It is determined that the 97110-Therapeutic exercises; 97530-Therapeutic activities; 99213-Office Visits; G0283-Electrical Stimulation; 97018-Paraffin bath; 97112-Neuromuscular re-education; 97140-Manual therapy; 95852-Neuromuscular Proc Evaluation hand; 96004-Phys review & interpretation; 97750-FC, Functional capacity all provided from 01/04/06 to 01/23/06 were medically necessary to treat this patient's condition.

Rationale/Basis for Decision

All services performed during the time frame were within national treatment guidelines, ODG and ACOEM guidelines for post operative rehabilitation. The weekly office visits were needed to assess, treat and direct the patient's care during the course of treatment. The patient was seen on 01/19/06 for a designated doctor's examination and was found not to be at maximum medical improvement.

The medical record documentation clearly states the specifics of this patient's injuries, the specific treatment that was rendered and the goals of the treatment. The patient did respond well to the post operative program and progressed into a work-hardening program. All of the treatments provided were utilized to assist the patient in rehabilitation of his hand, to improve his ADL's, to assist with his over all conditioning, and prepare him to return to the work force.

This decision by the IRO 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,

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:dm

Attachment

Information Submitted to TMF for Review

Patient Name: ____

Tracking #: M5-07-0104-01

Information Submitted by Requestor:

- Doctor's Position Statement For IRO Regarding Medical Necessity Denial
- Table of Disputed Services
- Official Disability Guidelines, 2005
- Decision Letter
- Request for Physiotherapy
- Treatment prescription
- ERGOS Evaluation Summary Reports
- Report of performance ratings
- Range of Motion Examination
- Preauthorization Request for Work Hardening
- ERGOS Assessment Job Placement Considerations
- Case Conference Notes
- Clinical SOAP Notes

Information Submitted by Respondent:

- Letter from Attorneys to TMF
- Clinical SOAP Notes
- Office notes form Dr. Small
- Range of motion exam
- ERGOS Evaluation Summary Reports
- Performance vs. Job Requirements
- Individual Psychotherapy Notes
- Designated Doctor Evaluation
- Chronic Pain Management Group Note
- Individual Psychotherapy Notes