



Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE 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:
North Dallas P.T. and Work Hardening
2035 Promenade
Richardson, TX 75080

MDR Tracking No.: M5-07-0450-01
Previous Tracking No.: M4-05-2562-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:
AMERICAN HOME ASSURANCE CO, BOX 19

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, "Rx and Documentation supports Medical Necessity."

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, "...Enclosed please find documents responsive to this issue for your review...No further recommendation of payment was recommended towards the amount in dispute of \$6,249.00"

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)
3-16-04 – 6-15-04	G0283, 97140, 97110, 97002, 97035	<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, 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 12-09-04 Medical Fee 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 97110 from 4-27-04 – 5-6-04 and 6-11-04 was denied by the carrier as “710 – This charge is being disallowed as additional/supporting documentation is required to clarify service/supply rendered. Please resubmit.” The Division declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the Requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Reimbursement not recommended.

CPT code G0283 from 4-27-04 – 5-6-04 and 6-11-04 was denied by the carrier as “710 – This charge is being disallowed as additional/supporting documentation is required to clarify service/supply rendered. Please resubmit.” The Requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F) and documentation per 133.301 (c) and (d). Recommend reimbursement per Rule 134.202(c)(1) of \$72.05 (\$14.41 x 1 unit x 5 days).

CPT code 97035 from 4-29-04 – 5-6-04 and 6-11-04 was denied by the carrier as “710 – This charge is being disallowed as additional/supporting documentation is required to clarify service/supply rendered. Please resubmit.” The Requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F) and documentation per 133.301 (c) and (d). Recommend per Rule 134.202(d)(2) reimbursement of \$63.32 (\$15.83 x 1 unit x 5 days).

CPT code 97140 on 6-11-04 was denied by the carrier as “710 – This charge is being disallowed as additional/supporting documentation is required to clarify service/supply rendered. Please resubmit.” The Requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F) and documentation per 133.301 (c) and (d). Recommend reimbursement Rule 134.202 (d)(2) of \$34.12.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.307, 133.308, 134.1 and 134.202
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 \$169.49. 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.

Decision by:

Medical Fee Dispute Officer

3-26-07

Authorized Signature

Typed Name

Date

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.



Specialty Independent Review Organization, Inc.

March 2, 2007

DWC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient: ____
DWC #: ____
MDR Tracking #: M5-07-0450-01
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI-Division of Workers' Compensation has assigned this case to Specialty IRO for independent review in accordance with DWC Rule 133.308, which allows for medical dispute resolution by an IRO.

Specialty IRO has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Doctor of Chiropractic. The reviewer is on the DWC ADL. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

The records received and reviewed indicated that the above patient was injured in a work related accident on _____. The injured employee was working as a cashier for _____ when he was injured. He was lifting merchandise when he injured his right shoulder. The injured employee originally reported to the emergency room and subsequently reported to Dr. Beaver's office for evaluation and management of his injuries. He reported to Dr. Beaver's office complaining of right shoulder pain. Dr. Beavers referred the patient for physical therapy. Dr. Beavers later placed him at MMI on 3-8-2004. The patient subsequently sought care with Dr. Taba and continued physical therapy.

RECORDS REVIEWED

Medical Dispute Resolution paperwork
Numerous EOB's
Treatment notes from Matrix Rehabilitation
Records from Dr. Beavers
MRI of Right Shoulder from Quantum Walnut Hill
Report from Arkansas Claims Management
Multiple reports from Consilium MD
Employer's First report of Injury or Illness
MMI/IR from Dr. Beavers 3-8-2004
Radiographic report of Right Shoulder
Reports from Dr. Mehdi
Report from Dr. Taba

DISPUTED SERVICES

The services under dispute include Electrical Stimulation G0283, Manual Therapy 97140, Therapeutic Exercises 97110, Physical Therapy Re-Evaluation 97002 and Ultrasound 97035 from 3/16/04 through 6/15/04.

DECISION

The reviewer agrees with the previous adverse determination.

BASIS FOR THE DECISION

The basis for the determination is based upon the Medical Disability Advisor, the Official Disability Guidelines, and Evidence Based Medicine Guidelines. The Medicare guidelines and payment policies were also utilized in the decision making process of this review. The AMA CPT Code Book was also utilized in this determination. The injured employee's treating doctor, Dr. Beavers, placed the injured employee at MMI with no impairment rating on 3-8-2004. Thus the treating doctor felt that the injured employee would not benefit from further care or therapy. The injured employee continued therapy but the documentation received does not provide reason for continuing therapy past the point of MMI as assigned by the injured employee's treating doctor. It does appear that the injured employee changed treating doctors to Dr. Taba at some point but there is insufficient documentation to this fact. There is also insufficient documentation to provide medical necessity as to why the injured employee continued with therapy past MMI. The injured employee also exceeds the normative treatment duration for a strain/sprain.

REFERENCES

Reed, P Medical Disability Advisor, 2005
Official Disability Guidelines
Evidence Based Medicine Guidelines
Medicare Guidelines and Payment Policies

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that the reviewing provider has no known conflicts of interest between that 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.

Sincerely,

Wendy Perelli, CEO

CC: Specialty IRO Medical Director

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,

Wendy Perelli, CEO

I hereby certify, in accordance with DWC- Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the Division via facsimile, U.S. Postal Service or both on this 7 day of March, 2007.

Signature of Specialty IRO Representative:

Name of Specialty IRO Representative: Wendy Perelli