



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: Summit Rehabilitation Centers 2420 East Randol Mill Road Arlington, Texas 76011-6335	MDR Tracking No.: M5-07-0531-01 (current MDR #) M4-06-4024-01 (former MDR #)
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Dallas National Insurance Company Rep Box # 20	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: "Provider sent a request for reconsideration on January 5, 2005. Proof that carrier received request is also included... All Fee guidelines have been followed."

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: "As indicated in the review of records of Dr. Buczek, any medical treatment after July 19, 2005 would not be indicated because Claimant ... would have been five weeks out from operative fixation and would be nearing a permanent and stationary point. Accordingly, Respondent should not be required to reimburse Requestor for any unnecessary services."

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)
09-08-05, 09-22-05, 10-06-05, 10-12-05, 10-20-05 and 10-27-05	99213 (\$65.44 X 6 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$392.64
10-06-05, 10-07-05 10-10-05, 10-11-05, 10-12-05, 10-18-05, 10-19-05, 10-20-05, 10-25-05 and 10-26-05	97110 (1 unit @ \$34.93 X 26 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$908.18
10-07-05	99080-73	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$15.00

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
10-10-05, 10-18-05, 10-20-05, 10-25-05 and 10-27-05	97035 (1 unit @ \$15.11 X 5 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$75.55
10-20-05, 10-25-05 and 10-27-05	97140 (1 unit @ \$33.04 X 3 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$99.12
10-27-05	97113 (1 unit @ \$40.05 X 3 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$120.15
10-06-05 to 10-27-05	95831, 95851, 96004, 99213 (except for DOS listed above), 97018, G0283, 97022 and 97124	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
TOTAL DUE			\$1,610.64

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 **majority** of 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 02-23-06, 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.

Review of CPT code 99080-73 billed for dates of service 08-19-05 and 09-16-05 revealed that neither party submitted a copy of the EOBs. Per Rule 133.307(e)(2)(B) the Requestor submitted convincing evidence of the Respondent's receipt of the Requestor's request for the EOBs. Reimbursement is recommended per Rule 129.5(i) in the amount of **\$30.00 (\$15.00X 2 DOS)**.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.1, 129.5(i) 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 \$1,640.64. In addition, the Division finds that the Requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of \$460.00. 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 Order by:

02-19-07

Authorized Signature

Typed Name

Date of Findings and 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.



Specialty Independent Review Organization, Inc.

AMENDED REPORT 2/15/2007

February 2, 2007

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

Patient:
DWC #:
MDR Tracking #: M5-07-0531-01
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 with a specialty in Rehabilitation. 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 above-mentioned person was injured on ___ while employed with _____. A beam fell on his arm while he was working. The injury resulted in multiple open fractures of the left radius and ulna. It was surgically repaired on _____ at John Peter Smith Hospital. He has been seen by Dr. Small, Dr. Farhat, Dr. Gonzalez, Dr. Swords, a designated doctor and Dr. Peterson. The IE has been treated with PT, stellate ganglion blocks, medications, surgery and passive therapies.

RECORDS REVIEWED

Records were received and reviewed from the requestor/treating doctor and from the respondent. Records from the requestor/TD include the following: 11/28/05 PPE, ODG 2005 pg. 2, 6/28/05 note by Dr. Small, 7/18/05 to 11/1/05 notes by F. Swords, DO, 11/3/05 script by Dr. Swords, 11/16/05 report by Total Pain Medicine and Anesthesiology (TPMA)/Dr. Farhat, 12/28/05 to 06/12/06 notes Dr. Farhat, 1/6/06 to 3/3/06 procedure notes by TPMA, 10/11/05 DD report by J Stephenson, MD, 5/21/06 DD report by Dr. Stephenson, 7/7/06 DD report by Dr. Stephenson, operative report _____, _____ through 6/15/06 notes by M Afrina, MD, J. James, MD, D. Mobely, MD and Z. Kelley, MD, John Peter Smith ortho trauma notes and Coded PK notes, SOAP notes from Dr. Gonzalez from 9/8/05 through 10/27/05, various TWCC 73's and 10/6/05 PPE.

Records from the requestor include the following (in addition to any previously mentioned records): 6/24/06 peer review report by R. Buczek, DC, DO, 8/8/05 by Dr. Buczek and multiple EOB's 8/19/05 through 10/27/05.

DISPUTED SERVICES

The disputed services include 99213 office visits, 95831 muscle testing, 95851 ROM, 96004 Physician review and interpretation of computer based motion analysis with written report, 97110 therapeutic exercise, 97124 massage therapy, 97018 paraffin bath, 97035 ultrasound, G0283 E-stim, 97022 whirlpool, 97140 manual therapy and 97113 aquatic therapy from 9/8/05 through 10/27/05 and 99080-73 on 10/7/05.

DECISION

The reviewer agrees with the previous adverse determination regarding 96004, 97124, 95831, 95851, 97022, 97018 and G0283.

The reviewer agrees with the previous adverse determination regarding 99213 on the following dates (10/7/05, 10/10/05, 10/11/05, 10/18/05, 10/19/05, 10/25/05 and 10/26/05).

The reviewer disagrees with the previous adverse determination regarding all remaining services.

BASIS FOR THE DECISION

According to the MDA, uncomplicated radial and ulnar fractures generally require no more than 6 weeks of treatment. However, this was not the case in this patient's presentation. The MDA allows for up to 168 days of disability for a very heavy PDL. This patient's PDL was not provided in the documentation.

The ODG indicates that code "813 fracture of radius and ulna allows for 16 PT visits over eight weeks..." Secondly under description, this code indicates "a fracture of one of the two bones in the lower arm..." This would indicate that this recommendation is based upon one fractured bone, either the radius or the ulna. It is the reviewer's assertion that these recommendations are not based upon both bones being broken and these recommendations are most certainly not based upon fractures in both bones of a compound nature. Dr. Buczek references the fact that "60 sessions of PT and chiropractic case management...was provided." According to the EOB's provided by the carrier (they did not provide treatment notes of any type) indicate that therapeutics were started on 10/6/05 and continued for 10 sessions of 97110. Thereafter aquatic therapy was started as per the daily notes and EOB's. The reviewer could not find anything approaching 60 visits in the records provided. The reviewer notes that as of 10/27/05 aquatic therapy was started; however, the daily notes do not indicate exactly as to why this change was necessary. However, the patient was not improving significantly, as per his pain scale; therefore, a change in treatment protocol is warranted. Therefore, code 97113 is approved.

Regarding codes 96004, 97124, 97022 and G0283, the physician interpretation is not helping the patient recover and therefore not medically necessary as per the TX Labor Code. 97124 is comparable to the code 97140 and is basically a duplication of the manual therapy code; therefore, it is denied. 97022-whirlpool therapy is a duplication of the 97113 code and is of no benefit to this patient as per the notes provided. Electrical stimulation at this point of care is not medically necessary as it is not likely to improve the patient's functionality. Regarding the ROM and MMT reports, the reviewer indicates that this is considered a portion of the 99213 code which was approved for this date of service. Therefore, these procedures were not medically necessary.

The reviewer indicates that the requestors own documentation indicates multiple SOAH decisions have indicated that weekly office visits are appropriate. However, the provider performed office visits on a generally several times per week schedule. The reviewer agrees that a treating doctor should maintain contact with a patient on a between one time per week to biweekly basis to direct care. Therefore, the approved 99213 visits are approved as described above.

As per Handoll in the Evidence Based Medicine Guidelines, ultrasound and myofascial release (manual therapy) are correctly utilized in this case to help reduce scar tissue formation and to increase the pliability of the scar tissue formation leading to increased ROM and functionality in this arm.

REFERENCES

Reed, P Medical Disability Advisor, 2005

Official Disability Guidelines

Handoll et al Rehabilitation for distal radial fractures in adults. Cochrane Database Review, 2004, 2 CD003324.

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 2nd day of February 2007

Signature of Specialty IRO Representative:

Name of Specialty IRO Representative: Wendy Perelli