



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 Rehab Center (Atlantis Healthcare Clinic, L.P.) 2420 East Randol Mill Road Arlington, Texas 76011-6335	MDR Tracking No.: M5-07-0587-01 (current MDR #) M5-04-3970-01 (former MDR #) M5-04-2305-01 (former MDR #)
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: National Fire Insurance Company Rep Box # 47	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: Per the Table of Disputed Services "Claim is compensable/Hand on the Right is compensable."

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: "Provider seeks reimbursement for chiropractic and physical therapy services provided to ___ ("Claimant") on dates of service 10/27/03 to 12/31/03. Carrier originally denied reimbursement for these services citing "E-entitlement to benefits." However, in May 2004 Carrier and Claimant entered into a Benefit Dispute Agreement (TWCC-24) whereby Carrier agreed to accept liability for a finger fracture. Pursuant to accepting liability for this claim, Carrier re-submitted these bills for audit in accordance with the applicable DWC fee guidelines, and most of the services were denied based on medical necessity. Accordingly, the SOAH Administrative Law Judge ("ALJ") has issued an Order of Remand in this dispute, asking the MRD send these services to an IRO for review of the medical necessity issues pursuant to pursuant to DWC rules 133.305(a)(4) and 133.308."

Principle Documentation: Response to DWC 60

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Amount Due
10-27-03 & 11-28-03	99080-73 (\$15.00 X 2 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$30.00
10-27-03	99203	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$119.53
10-27-03	73120-WP (see note below)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$31.26

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Amount Due
10-29-03, 11-03-03, 12-09-03, 12-16-03, 12-17-03	97110 (1 unit @ \$35.90 X 3 units X 5 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$538.50
11-05-03, 11-06-03, 11-11-03, 11-12-03, 11-18-03, 11-26-03, 12-03-03 and 12-04-03	97110 (1 unit @ \$35.90 X 2 units X 8 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$574.40
12-12-03	97110 (\$107.70 minus payment of \$70.00)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$37.70
12-22-03	97110 (\$107.70 minus payment of \$39.62)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$68.08
11-03-03, 11-05-03, 11-06-03, 11-11-03, 11-13-03, 11-18-03, 11-26-03, 12-03-03, 12-09-03, 12-16-03 and 12-17-03	G0283 (1 unit @ \$16.63 X 11 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$182.93
11-05-03, 11-12-03, 11-19-03, 11-26-03, 12-03-03, 12-10-03 and 12-17-03	99213 (\$66.19 X 7 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$463.33
11-11-03 & 12-09-03	95852 (1 unit @ \$28.55 X 2 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$57.10
11-18-03	97750 (1 unit @ \$36.94 X 2 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$73.88
11-26-03, 12-03-03, 12-04-03, 12-09-03, 12-16-03 & 12-17-03	97018 (1 unit @ \$6.88 X 6 DOS) (see note below)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$41.28
11-26-03, 12-10-03, 12-11-03, 12-16-03, 12-17-03 and 12-22-03	97140 (1 unit @ \$34.05 X 6 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$204.30
12-02-03	95832	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$35.94
12-15-03	96004	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$143.95
	Note: The Requestor billed less than MAR. Reimbursement is recommended per Rule 134.202(d)(2)		
	TOTAL DUE		\$2,602.18

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.

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 08-11-2004, 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.

The Requestor submitted a Revised Table of Disputed Services on 02-21-2007 which is used for the review by Medical Dispute Resolution.

CPT code 95851(1unit) billed for date of service 10-30-03 was denied by the Respondent with denial code "F" (Fee Guideline MAR reduction). The Respondent has not made a payment. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$35.78**.

HCPCS code A4556 billed for date of service 10-30-03 was denied by the Respondent with denial code "G" (Unbundling. Payment denied – the service is included in the global value of another billed procedure). Per Rule 134.202(b) HCPCS code A4556 is a bundled code. No reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.1, 129.5 and 134.202
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 \$2,637.96. 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:

04-26-07

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.

MEDICAL REVIEW OF TEXAS

[IRO #5259]

10817 W. Hwy. 71
Phone: 512-288-3300

Austin, Texas 78735
FAX: 512-288-3356

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	
MDR Tracking Number:	M5-07-0587-01
Name of Patient:	
Name of URA/Payer:	National Fire Insurance Co.
Name of Provider: (ER, Hospital, or Other Facility)	Summit Rehab Centers
Name of Physician: (Treating or Requesting)	R. Todd Peterson, DC

March 20, 2007

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on the Division of Workers' Compensation Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Division of Workers' Compensation

DOCUMENTS REVIEWED

Notification of IRO Assignment
Table of Disputed Services
Response to IRO Request, Stone Loughlin & Swanson, LLP
Benefit Dispute Agreement
Peer Review Reports, George Medley, MD
Peer Review Reports, Mike O'Kelley, DC
Medical Reports & Notes, Ronald F. Mahr, MD,
Surgery Reports & Notes, Saeed Beg, MD
Chiropractic Reports and Notes, R. Todd Peterson, DC
Medical Reports & Notes, Charles Murphy, MD
Behavioral Medicine Reports, Felisha Hernandez, LPC
Medical Reports, Andrew Small, MD
Medical Orthopedic Reports, Robert Chouteau, DO
Designated Doctor Evaluation, Sheryl Tollenaar, DC
ROM Tests and Rehab Notes, Hui Li, OTR

CLINICAL HISTORY

Based on materials provided for review, it appears that this patient reports an occupational injury to his right hand when he was drilling a hole in a wall and the machine barrel and rod kicked back. He was seen the same day at an Occumed facility and was treated conservatively. He was later referred to a hand specialist, Saaed Beg, MD and had surgery performed on 10/03/03 for screw instrumentation and stabilization of the fourth metacarpal. Repeat surgery was performed to remove the screws several weeks later. The patient later presents to R. Todd Peterson, DC for chiropractic treatment and post surgical therapy 10/29/03 through 12/22/03. The patient was referred back to the treating surgeon to determine stabilization and rehabilitation status, but was told that this doctor no longer accepts worker's compensation patients. Orthopedic follow-up assessment was made with Robert Chouteau, DO, who indicates that the patient is improving with physical therapy and should continue three-times weekly with ROM, strengthening and modalities as directed. Designated Doctor Evaluation was made 12/24/03 by a Sheryl Tollenaar, DC, suggesting that the patient had achieved MMI with 11% WP impairment.

REQUESTED SERVICE(S)

Determine Medical Necessity & Appropriateness of Treatment (Items in Dispute 10/27/03 – 12/22/03): 99080-73 DWC Report, 99203 and 99213 office visits, 73120-WP x-ray, 97110 therapeutic exercises, GO283 electric stimulation, 95832 muscle testing, 95852 neuromuscular evaluation, 97750-FC functional capacity evaluation, 97018 paraffin bath, 97140 manual therapy, and 96004 physician review of motion tests.

DECISION

Approved

RATIONALE/BASIS FOR DECISION

Though chiropractic and OTR notes are poorly documented as to what specifically is done, for what purpose and for what specific goals, this level of care **does appear to be within usual and customary post surgical therapeutic applications for conditions of this nature.** According to ODG and other cited references, this does appear to be within conservative 'best practices' for level, frequency and duration of care for this compensable disorder.

ODG, Best Practices Disability Guidelines, Work Loss Data Institute, January 2005.

Higgs P, Collin E, Martin E: Hand Fractures and Dislocation. In: Manual of Acute Hand Injuries. Mosby-Year Book; 1998: 346-403.

Hossfeld GE, Uehara DT: Acute joint injuries of the hand. Emerg Med Clin North Am 1993 Aug; 11(3): 781-96.

Toth-Fejel GE, Toth-Fejel GF, Hedricks CA: Occupation-centered practice in hand rehabilitation using the experience sampling method. Am J Occup Ther 1998 May; 52(5): 381-5

Weeks PM: Hand injuries. Curr Probl Surg 1993 Aug; 30(8): 721-807

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials. No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned claimant. These opinions rendered do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.

Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that I have no known conflicts of interest between the 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.

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.

Chief Clerk of Proceedings
Division of Workers' Compensation
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell