



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 Dispute

PART I: GENERAL INFORMATION

| | |
|--|---------------------------------|
| Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier | |
| Requestor's Name and Address: Texas Orthopedic & Injury Center P O BOX 11527 Houston, Texas 77293 | MDR Tracking No.: M5-07-0669-01 |
| | Claim No.: |
| | Injured Employee's Name: |
| Respondent's Name and Address: Indemnity Insurance Company Rep Box # 15 | Date of Injury: |
| | Employer's Name: |
| | Insurance Carrier's No.: |

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: "I am requesting an MDR for the above named patient for the following reasons. 1. On 11-15-06 I disputed the RME report showing that there was a more current report that contradicted previous doctors report. 2. Over a month has passed with no response from adjustor or any other representative.

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: Per the Table of Disputed Services "no change bills remain denied."

Principle Documentation: 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) |
|--------------------|----------------------------|---|--------------------------------|
| 05-16-06 | 99203 | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | \$0.00 |
| 05-30-06 | 99245 | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | \$0.00 |
| 06-07-06 | 99213 | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$67.24 |
| TOTAL DUE | | | \$67.24 |

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 **majority** of the disputed medical necessity issues.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 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 \$67.24. In addition, the Division finds that the Requestor was not the prevailing party and is not entitled to a refund of the IRO fee. 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:

04-30-07

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

REVISED 3/28/07

| | |
|--|------------------|
| TDI-WC Case Number: | |
| MDR Tracking Number: | M5-07-0669-01 |
| Name of Patient: | |
| Name of URA/Payer: | Texas Orthopedic |
| Name of Provider: (ER, Hospital, or Other Facility) | Texas Orthopedic |
| Name of Physician: (Treating or Requesting) | Mark Yezak, DC |

March 21, 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

1. Notification of IRO Assignment, Table of Disputed Services, Carrier EOBs
2. Initial "company doctor's" notes, records and physical therapy notes
3. Treating doctor medical reports/narratives, physical therapy notes and evaluations, multiple dates
4. Referral orthopedist's medical reports/narratives
5. Referral orthopedist's narrative note, dated 6/7/2006
6. Computerized muscle testing and range of motion reports, dated 5/16/2006 and 5/30/2006
7. Orthopedic consultant report, dated 5/30/2006
8. Required medical exam and report, dated 6/28/2005
9. MRIs with reports of right knee, left shoulder and lumbar spine, dated 8/8/2005
10. MRI and report of right shoulder, dated 8/11/2006
11. Carrier peer review, dated 7/15/2006
12. Initial Designated Doctor DWC-69 and impairment rating evaluation/report, dated 2/22/2006
13. Amended Designated Doctor DWC-69 and impairment rating evaluation/report, dated 8/9/2006

14. Treating doctor's "Dispute of Date of Designated Doctor Findings & Determination of Maximum Medical Improvement" letter, dated 1/25/2007
15. Various DWC-73s

CLINICAL HISTORY

Patient is a 57-year-old diabetic delivery driver for an auto parts company who, on ___, was walking through the back of the shop when she tripped and fell over a wooden pallet. In the process of falling, she twisted her right knee, and landed on the ground with her left arm outstretched. She immediately experienced pain in her bilateral shoulders, her right knee and her lower back. The company doctor who diagnosed sprain/strains of the left shoulder and lower back, and recommended physical therapy first saw her. Shortly after initiating care, her claim was denied by the carrier.

The claimant then sought a change of treating doctors and presented herself to a doctor of chiropractic for chiropractic care, physical therapy and rehabilitation. Subsequent MRIs revealed right knee joint effusion, a non-displaced fracture of the medial femoral condyle, sprain of the anterior cruciate ligament, and sprain of the medial collateral ligament; partial tear with tendonitis of the left rotator cuff, bursal fluid, small full thickness tear of the rotator cuff, and possible disruption of the glenoid labrum; and, 2-3 mm disc bulges, with posterior herniations, in the lumbar spine herniations from L3 to S1. An MRI to the right shoulder was later performed on 8/11/2006, and it revealed a small full thickness supraspinatus critical zone tear and a subchondral cyst in the posterior inferior glenoid.

REQUESTED SERVICE(S)

New patient Evaluation and Management service, level III (99203), established patient Evaluation and Management service, level III (99213), and consultation Evaluation and Management service, level III (99245) for dates of service 5/16/06 through 6/7/06.

DECISION

The level III established patient Evaluation and Management service (99213) for date of service 6/7/2006 is approved; all remaining services are denied.

RATIONALE/BASIS FOR DECISION

The first service in dispute in this case is the level III Evaluation and Management (E/M) service for a new patient, *Current Procedural Terminology* ("CPT") 1, code 99203.

According to CPT, this service includes the performance of an evaluation that bears components of a detailed history, a detailed examination, and medical decision-making of low complexity. The medical records in this case clearly indicated that this claimant was already seeing and receiving care from numerous providers for her injuries. Therefore, it was not supported as medically necessary for her to receive such a high level, "detailed" E/M service at that point in her care. In addition, the documentation was insufficient to support the reporting of this service, particularly since a major component of this evaluation was the range of motion and muscle strength testing also performed on that date, yet those were—according to the billing records—reported separately, and already considered, as 95831 and 95851.

Insofar as the E/M service performed on 5/30/2006 was concerned, nothing in the medical records submitted supported the rationale or medical necessity substantiating the need for this orthopedic consultative service, particularly since the patient was already under the care of an orthopedic surgeon practicing in the very same provider group.

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

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