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: Main Rehab and Diagnostic/Administrative Office 3500 Oak Lawn, Suite 380 Dallas, TX 75219	MDR Tracking No.: M5-06-0991-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Zurich American Insurance Company, Box 19	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 package. Position summary states, "We are requesting the carrier be ordered to pay for these reasonable and necessary medical bills."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response. Position summary states, "Fair and reasonable reimbursement made."

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)
7-20-05 – 10-6-05	CPT code 97112-QU-GP ($35.66 X 4 DOS + $36.78 X 6 DOS)	☒ Yes ☐ No	$363.32
7-20-05 – 10-6-05	CPT code 97110-QU-GP ($34.93 X 33 units + $29.10) The respondent reimbursed $42.28 for DOS 8-23-05.	☒ Yes ☐ No	$1,181.79
7-20-05 – 10-6-05	CPT code 97530-QU-GP	☒ Yes ☐ No	$36.11
7-20-05 – 8-20-05	CPT code 97124-QU-GP ($27.33 X 2 DOS)	☒ Yes ☐ No	$54.66
7-20-05 – 8-20-05	CPT code 97032-QU-GP ($19.46 X 2 DOS)	☒ Yes ☐ No	$38.92
8-22-05 – 10-6-05	CPT code 97124-QU-GP, CPT code 97032-QU-GP	☐ Yes ☒ No	0
	Grand Total		$1,674.80

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. The amount due the requestor for the items denied for medical necessity is $1,674.80.

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 2-15-06 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.

Regarding CPT codes 99211-QU, 97112-QU-GP and 97110-QU-GP on 9-28-05. These services were denied as "Payment denied/reduced for absence of, or exceeded, pre-certification/authorization." Per Rule 134.600 these services do not require preauthorization. Recommend reimbursement as follows:

99211 QU – $26.25
97112-QU-GP – $36.78
97110-QU-GP - $104.79 – The requestor documented "The patient was directly supervised with one-on-one contact when he was performing rehabilitation."
Total of services for 9-28-05 is $167.82.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and Rule 134.202(c)(1).

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 carrier 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 $1,842.62. The Division hereby **ORDERS** the insurance carrier 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:

	Donna Auby	3-23-06
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

March 21, 2006

Program Administrator
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 #: M5-06-0991-01
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 ___. He was carrying a heavy iron door weighing approximately 75 pounds. He was attempting to load the door when he accidentally slipped and fell on his back and buttocks. The patient underwent a laminectomy on 06/07/2005. He was seen for follow up visits to his surgeon on 07/07/2005 and was given a prescription for post surgical therapy.

Requested Service(s)

(97112-QUGP) neuromuscular re-education, (97110-QUGP) therapeutic exercises, (97530- QUGP) therapeutic activities, (97124-QUGP) massage therapy, and (97032-QUGP) electrical stimulation provided from 07/20/2005 through 10/06/2005

Decision

It is determined that 97112-QUGP) neuromuscular re-education, (97110-QUGP) therapeutic exercises, (97530-QUGP) therapeutic activities provided from 07/20/2005 through 10/06/2005 and the (97124-QUGP) massage therapy, and (97032-QUGP) electrical stimulation provided from 07/20/2005 through 08/20/2005 were medically necessary to treat this patient's condition.

It is determined (97124-QUGP) massage therapy, and (97032-QUGP) electrical stimulation provided from

08/20/2005 through 10/06/2005 was not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The medical record documentation substantiates the medical necessity for post-operative care. National treatment guidelines allow for post-operative rehabilitation. Passive therapy to include massage therapy and electrical stimulation is acceptable for up to one month post-op. This would indicate those passive services from 07/20/2005 through 08/20/2005 would be medically necessary. Active therapy in the form of neuromuscular re-education, therapeutic exercises and therapeutic activities are allowed for a period of 2 to 4 months post-op. The treatment that this patient received falls within this allowable frame with regard to the active therapy he received from 07/20/2005 through 10/06/2005.

Therefore, there is sufficient documentation to clinically justify one month of passive therapy (massage therapy and electrical stimulation) and 2 ½ months of active therapy (neuromuscular re-education, therapeutic exercises and therapeutic activities) this patient received post surgically.

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 (other that a spinal surgery prospective 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. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

Sincerely,

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

GBS:dm
Attachment

Attachment

Information Submitted to TMF for Review

Patient Name:

Tracking #: M5-06-0991-01

Information Submitted by Requestor:

- **Letter of medical necessity**
- **Follow up office visits**
- **Office notes**
- **Functional Abilities Evaluation**

Information Submitted by Respondent:

- **Position Letter from Broadspire**
- **Notice of Retrospective Determination**
- **Notice of Reconsideration**