



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:

Gilda Morales, D. C.  
8989 Forest Lane #146  
Dallas, TX 75243

MDR Tracking No.: M5-04-4194-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:

American Protection Insurance, Box 42

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.

#### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response. Position paper states that no reimbursement is owed based on the Chiropractic review."

See note below.

#### 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)
4-16-03	CPT code 99213	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$48.00
8-27-03	CPT code 99211	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0

#### 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 \$48.00.

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 2-28-06 a representative of the insurance carrier stated that there is no contract on this dispute as was stated on the EOB's. This representative also stated that no payments had been made to the requestor for these services. The carrier submitted a letter dated 5-10-04 which stated that these services were being disputed "on the basis of not reasonable and necessary per Chiropractic review." However, this letter was received by MDR on 9-23-04 which was not timely.

On 9-15-04 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.

On 2-28-06 a representative of the insurance carrier stated that there is no contract on this dispute as was shown on the EOB's. This representative also stated that no payments had been made to the requestor for these services. The carrier submitted a letter dated 5-10-04 which stated that these services were being disputed "on the basis of not reasonable and necessary per Chiropractic review." However, this letter was received by MDR on 9-23-04 which was not timely.

CPT code 97014 on 4-16-03 was denied by the carrier as "F-fee guideline MAR reduction." The carrier made no payment and gave no valid reason for not doing so. Recommend reimbursement per the 1996 MFG of \$15.00.

CPT code 97012 on 4-16-03 was denied by the carrier as "F-fee guideline MAR reduction." The carrier made no payment and gave no valid reason for not doing so. Recommend reimbursement per the 1996 MFG of \$20.00.

CPT code 97250 on 4-16-03 was denied by the carrier as "F-fee guideline MAR reduction." The carrier made no payment and gave no valid reason for not doing so. Recommend reimbursement per the 1996 MFG of \$43.00.

CPT codes 99080-73, 97014, 99213, 97012, 97250, 99090, 97124 and 97010 from 7-2-03 through 8-27-03 were denied by the carrier as "C - negotiated contract price." The EOB's show that a payment was made to the requestor. The carrier states that no payment was actually made. The carrier states that it has no contract with the requestor. Therefore, recommend reimbursement as follows:

CPT code 99080-73 - \$15.00

CPT code 97014 - \$15.00

CPT code 99213 - \$48.00

CPT code 97012 - \$40.00 (2 units)

CPT code 97250 - \$43.00

CPT code 99090 - \$108.00

CPT code 97124 - \$28.00

CPT code 97010 - \$11.00

#### **PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. 133.307, 133.308 and 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 \$434.00. 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

3-8-06

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.**

October 22, 2004

## NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M5-04-4194-01**  
**TWCC #:**  
**Injured Employee:**  
**Requestor:**  
**Respondent:**  
**----- Case #:**

----- has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ----- IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ----- for independent review in accordance with this Rule.

----- has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ----- external review panel who is familiar with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ----- chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ----- for independent review. In addition, the ----- chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

### Clinical History

This case concerns a 60 year-old female who sustained a work related injury on ----- . The patient reported that while at work she injured her back, neck and bilateral wrists when she fell from a ladder. An EMG performed on 6/23/03 was reported to have shown right C7 radiculopathy and right carpal tunnel neuropathy, indicating decrease in neuromuscular function. An MRI performed on 4/22/03 was reported to have shown minimal facet joint prominence present in the lower lumbar region. The diagnoses for this patient have included cervical strain/sprain, spasm, back muscles, lumbosacral strain/sprain, cervical radiculitis, right ankle sprain/strain, and post-traumatic headaches. Treatment for this patient's condition has included physical therapy consisting of physiotherapies and chiropractic manipulations, and oral medications.

### Requested Services

Office visits 4/16/03 and 8/27/03.

### Documents and/or information used by the reviewer to reach a decision:

#### *Documents Submitted by Requestor:*

1. Initial FCE 7/8/03
2. Work Hardening Daily Flow Sheet/Progress Notes 3/3/03 – 9/9/03
3. Final FCE 9/9/03

#### *Documents Submitted by Respondent:*

1. SOAP Notes 6/2/03 – 8/22/03
2. Final Impairment Examination 3/7/03

3. SOAP Notes 4/28/03 - 11/21/03
4. Work Hardening Daily Notes 7/22/03 – 9/8/03
5. Elbow and Wrist Therapeutic Procedures Chart 6/4/03 – 6/20/03

*Additional Records Used by the Reviewer to Reach a Decision:*

1. Notification of IRO Assignment
2. Designated Doctor Examination 10/2/03
3. EMG Report 6/23/03
4. SOAP Notes 9/17/03 and 10/1/03
5. Initial Report from Treating Doctor 3/26/03
6. Daily Treatment Notes/Medical Necessity forms 4/16/03 and 8/27/03
7. MRI Reports 4/22/03

**Decision**

The Carrier's denial of authorization for the requested services is partially overturned.

**Rationale/Basis for Decision**

The ----- chiropractor reviewer noted that this case concerns a 61 year-old female who sustained a work related injury to her back, neck and bilateral wrists on ----- . The ----- chiropractor reviewer explained that the medical records adequately established that a compensable injury had occurred to this patient in multiple regions of her body. The ----- chiropractor reviewer indicated that spinal manipulation was medically necessary for treatment of this patient's condition. The ----- chiropractor reviewer explained that prior to 8/1/03, the TWCC Medical Fee Guideline states that 99213-MP was the appropriate way to report the performance of the spinal manipulative procedure. However, the ----- chiropractor reviewer also explained that according to the American Medical Associations Current Procedural Terminology (CPT), chiropractic manipulative treatment procedures contain within them inherent pre-, intra- and post-service work. The ----- chiropractor reviewer indicated that the documentation adequately reflected that a CMT service was provided and reported on date of service 8/27/03, the service within CPT 99211 – a minimal evaluation and management service – would have already been performed as a component of the CMT service. Therefore, the ----- chiropractor consultant concluded that the office visit 99213-MP for date of service 4/16/03 was medically necessary to treat this patient's condition. However, the ----- chiropractor consultant further concluded that the office visit 99211 for date of service on 8/27/03 was not medically necessary to treat this patient's condition.

Sincerely,

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State Appeals Department