

MDR Tracking #M5-05-1625-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 2-4-05.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

CPT code 99214 from 9-17-04 through 11-22-04 **was found** to be medically necessary. CPT codes 97110, 97112 and 99090 from 9-17-04 through 11-22-04 **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services. The amount due the requestor for the medical necessity issues is \$85.09, which is what the requestor billed for this service.

All services were denied by the carrier with a "V – unnecessary treatment with a peer review." However, the carrier states on a form to the requestor that this injury had not been adjudicated by TWCC. A contested case hearing was held on 1-6-04. The findings of that hearing were that the claimant sustained a compensable injury.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity issues were not the only issues involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 3-10-05 the Medical Review Division submitted a Notice to the 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 carrier denied CPT Code 99080-73 on 6-28-04 and 12-1-04 with a V for unnecessary medical treatment, however, the TWCC-73 is a required report and is not subject to an IRO review per Rule 129.5. A referral will be made to Compliance and Practices for this violation. The Medical Review Division has jurisdiction in this matter and, therefore, recommends reimbursement. Requestor submitted relevant information to support delivery of service. **Recommend reimbursement of \$30.00.**

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees totaling \$115.09 from 6-28-04 through 12-1-04 outlined above as follows:

- In accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c);
- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this Order.

This Decision and Order is hereby issued this 18<sup>th</sup> day of May, 2005.

Medical Dispute Resolution Officer  
Medical Review Division

Enclosure: IRO decision

Parker Healthcare Management Organization, Inc.  
3719 North Belt Line Road, Irving, TX 75038  
972.906.0603 972.906.0615 (fax)  
Certificate # 5301

May 16, 2005

**ATTN: Program Administrator**  
**Texas Workers Compensation Commission**  
Medical Dispute Resolution, MS-48  
7551 Metro Center Drive, Suite 100  
Austin, TX 78744  
Delivered by fax: 512.804.4868

## Notice of Determination

MDR TRACKING NUMBER: M5-05-1625-01  
RE: Independent review for \_\_\_\_

The independent review for the patient named above has been completed.

- Parker Healthcare Management received notification of independent review on 3.14.05.
- Telephone request for provider records made on 3.15.05.
- Complete set of records received for review on 4.27.05.
- The case was assigned to a reviewer on 5.2.05.
- The reviewer rendered a determination on 5.12.05.
- The Notice of Determination was sent on 5.16.05.

The findings of the independent review are as follows:

### Summary of Clinical History

The patient was injured while working for \_\_\_\_\_. At appears that the causation of her symptoms have been linked to repetitive stress while working as a cake decorator. The date of injury was listed as \_\_\_\_.

### Questions for Review

The therapy in question ranges from the dates of 9.17.04 through 11.22.04. The denial was based upon a "V" code demonstrating a lack of medical necessity for the listed care:  
97110-Therapeutic Exercise, 97112-Neuromuscular Re-education, 99090-Analysis of clinical data, and 99214-office visits

## Determination

PHMO, Inc. has performed an independent review of the proposed care to determine if the adverse determination was appropriate. After review of all medical records received from both parties involved, the PHMO, Inc. physician reviewer has determined to **uphold the denial** of CPT codes 97110, 97112, and 99090, through the dates of 9.17.04 through 11.22.04.

It was determined to **overturn the denial** regarding the CPT code 99214, through the dates of service 9.17.04 through 11.22.04.

## Clinical Rationale

The documentation during the time in question does not outline any specific changes in the patient's pain scale. It has remained the same throughout the patient's course of care. Furthermore, the documentation does not include clear objective outcome assessments that demonstrate progress or improvement during the care in question. The office visits were necessary to allow the attending doctor to monitor the patient's condition.

## Clinical Criteria, Utilization Guidelines or other material referenced

- *Occupational Medicine Practice Guidelines*, Second Edition.
- *The Medical Disability Advisor*, Presley Reed MD
- *A Doctors Guide to Record Keeping*, Utilization Management and Review, Gregg Fisher

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The reviewer for this case is a doctor of chiropractic peer matched with the provider that rendered the care in dispute. The reviewer is engaged in the practice of chiropractic on a full-time basis.

The review was performed in accordance with Texas Insurance Code §21.58C and the rules of the Texas Workers Compensation Commission. In accordance with the act and the rules, the review is listed on the TWCC's list of approved providers, or has a temporary exemption. The review includes the determination and the clinical rationale to support the determination. Specific utilization review criteria or other treatment guidelines used in this review are referenced.

The reviewer signed a certification attesting that no known conflicts-of-interest exist between the reviewer and any of the providers or other parties associated with this case. The reviewer also attests that the review was performed without any bias for or against the patient, carrier, or other parties associated with this case.

In accordance with TWCC Rule 102.4 (h), a copy of this decision was sent to the TWCC via facsimile, U.S. Postal Service or both on this 16th day of May, 2005. The TWCC Medical Dispute Resolution department will notify all other parties involved incase of determination.

If our organization can be of any further assistance, please feel free to contact me.

Sincerely,

Meredith Thomas  
Administrator

CC: Jupiter Health Works  
Fax: 817.429.4665

CC: c/o FOL  
Attn: Annette Moffett  
Fax: 512.867.1733

CC: —