



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: Integra Specialty Group, P.A. 517 North Carrier Parkway, Suite G Grand Prairie, Texas 75050	MDR Tracking No.: M5-05-1736-01
	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

DOCUMENTATION SUBMITTED: DWC-60 dispute package
 POSITION SUMMARY: Per table of disputed services "Medically necessary"

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60
 POSITION SUMMARY: No position summary submitted by Respondent

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)																														
04-09-04 to 07-08-04	96004	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00																														
04-09-04 to 07-08-04	<p>95851 and 95831 NOTE: Although found to be medically necessary by the IRO reviewer code 95851 and 95831 per the 2002 MFG is a component procedure of code 99213 billed on the dates of service in dispute. There are no circumstances in which a modifier would be appropriate. The services represented by the code combination will not be paid separately.</p> <table style="width: 100%; border: none;"> <tr><td style="width: 10%;">97110</td><td style="width: 30%;">(\$110.97 X 19)</td><td style="width: 10%; text-align: right;">=</td><td style="width: 10%;">\$2,108.43</td><td style="width: 30%;"></td></tr> <tr><td>97140</td><td>(\$34.13 X 20)</td><td style="text-align: right;">=</td><td>\$682.60</td><td></td></tr> <tr><td>99213</td><td>(\$68.24 X 18)</td><td style="text-align: right;">=</td><td>\$1,228.32</td><td></td></tr> <tr><td>97012</td><td>(\$19.21 X 1)</td><td style="text-align: right;">=</td><td>\$19.21</td><td></td></tr> <tr><td>97032 (2 u ea DOS)</td><td>(\$40.40 X 10)</td><td style="text-align: right;">=</td><td>\$404.00</td><td></td></tr> <tr><td>97750</td><td>(\$592.80 X 1)</td><td style="text-align: right;">=</td><td>\$592.80</td><td></td></tr> </table> <p>97010 (Reimbursement for code 97010 is included in the reimbursement for the comprehensive therapeutic code(s). Therefore, additional payment cannot be recommended.)</p>	97110	(\$110.97 X 19)	=	\$2,108.43		97140	(\$34.13 X 20)	=	\$682.60		99213	(\$68.24 X 18)	=	\$1,228.32		97012	(\$19.21 X 1)	=	\$19.21		97032 (2 u ea DOS)	(\$40.40 X 10)	=	\$404.00		97750	(\$592.80 X 1)	=	\$592.80		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$5,035.36
97110	(\$110.97 X 19)	=	\$2,108.43																														
97140	(\$34.13 X 20)	=	\$682.60																														
99213	(\$68.24 X 18)	=	\$1,228.32																														
97012	(\$19.21 X 1)	=	\$19.21																														
97032 (2 u ea DOS)	(\$40.40 X 10)	=	\$404.00																														
97750	(\$592.80 X 1)	=	\$592.80																														
		Total	\$5,035.36																														

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

An updated table of disputed services was received from the Requestor on 12-05-05 and is used for the review. Per the updated table dates of service 07-12-04 through 08-09-04 (with the exception of code 99080-73 on date of service 07-23-04) were paid by the carrier and are no longer in dispute and will therefore not be a part of the review.

Based on review of the disputed issues within the request, the Medical Review 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 03-21-2005, 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.

Review of CPT code 97012 date of service 02-20-04 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of a request for an EOB. Reimbursement is recommended in the amount of **\$19.21**.

Review of CPT code 97110 (19 units total) dates of service 02-20-04 (2 units), 02-24-04 (2 units), 03-02-04 (3 units), 05-25-04 (3 units), 06-01-04 (3 units), 06-04-04 (3 units) and 06-08-04 (3 units) revealed that neither party submitted a copy of EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of a request for EOBs. Reimbursement is recommended in the amount of **\$702.81 (\$36.99 X 19 units)**.

Review of CPT code 97140 dates of service 02-20-04, 02-24-04, 03-02-04, 05-25-04, 06-01-04, 06-04-04 and 06-08-04 revealed that neither party submitted a copy of EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of a request for EOBs. Reimbursement is recommended in the amount of **\$238.91 (\$34.13 X 7 DOS)**.

Review of CPT code 99213 dates of service 02-20-04, 02-24-04, 03-02-04, 05-25-04, 06-01-04, 06-04-04 and 06-08-04 revealed that neither party submitted a copy of EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of a request for EOBs. Reimbursement is recommended in the amount of **\$477.68 (\$68.24 X 7 DOS)**.

Review of CPT code 95851 date of service 02-24-04 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of a request for an EOB, however, per the 2002 MFG 95851 is a component procedure of code 99213 billed on the date of service in dispute. There are no circumstances in which a modifier would be appropriate. The services represented by the code combination will not be paid separately.

Review of CPT code 96004 dates of service 02-24-04, 03-02-04 and 06-01-04 revealed that neither party submitted a copy of EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of a request for EOBs. Reimbursement is recommended in the amount of **\$458.25**.

Review of CPT code 97032 (2 units each date of service for a total of 10 units) dates of service 02-24-04, 05-25-04, 06-01-04, 06-04-04 and 06-08-04 revealed that neither party submitted a copy of EOBs. Per Rule 133.307(e)(2)(B) the

requestor provided convincing evidence of carrier receipt of a request for EOBs. Reimbursement is recommended in the amount of **\$202.00**.

Review of CPT code 97124 date of service 02-24-04 04 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of a request for an EOB. Reimbursement is recommended in the amount of **\$28.40**.

Review of CPT code 95833 date of service 03-02-04 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of a request for an EOB, however, however per the 2002 MFG 95833 is a component procedure of code 99213 billed on the date of service in dispute. There are no circumstances in which a modifier would be appropriate. The services represented by the code combination will not be paid separately.

Review of CPT code 95831 date of service 06-01-04 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of a request for an EOB, however per the 2002 MFG 95831 is a component procedure of code 99213 billed on the date of service in dispute. There are no circumstances in which a modifier would be appropriate. The services represented by the code combination will not be paid separately.

CPT code 99080-73 dates of service 04-23-04, 05-23-04, 06-23-04, 07-23-04, 08-23-04 and 09-23-04 denied with denial code "V" (unnecessary treatment with peer review). Per Rule 129.5 the DWC-73 is a required report and not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. Reimbursement is recommended in the amount of **\$90.00 (\$15.00 X 6 DOS)**.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.202(c)(1), 129.5, 133.307(e)(2)(B)

PART VII: DIVISION DECISION 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 additional reimbursement in the amount of \$7,252.62.

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 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 by:

01-04-06

Authorized Signature

Date of Findings and Decision

Order by:

01-04-06

Authorized Signature

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.

December 21, 2005

Amended: December 29, 2005

Amended: December 30, 2005

ATTN: Program Administrator
Texas Department of Insurance/Workers Compensation Division

7551 Metro Center Drive, Suite 100

Austin, TX 78744

Delivered by fax: 512.804.4868

Notice of Determination

MDR TRACKING NUMBER: M5-05-1736-01

RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 11.16.05.
- Faxed request for provider records made on 11.21.05.
- TDI-DWC issued an Order for Payment on 11.29.05.
- The case was assigned to a reviewer on 12.9.05.
- The reviewer rendered a determination on 12.20.05.
- The Notice of Determination was sent on 12.21.05.

The findings of the independent review are as follows:

Questions for Review

The services that are in question include 95851 (ROM), 96004 (Physician review of motion test), 97110 (Therapeutic exercise), 97140 (Manual therapy technique), 99213 (Office visit), 95831 (Muscle test), 97012 (Mechanical traction), 97032 (Electrical stimulation), 97010 (Hot / Cold pack), 97750 (FCE), 97035 (Ultrasound) and 99214 (office visit). The dates of service that are in question include 4.9.04 thru 7.08.04.

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 **overturn the denial** on the denied service(s) that occurred from 4.9.04-5.20.04 to include only CPT codes: 97032 (Electrical stimulation), 97035 (Ultrasound) and 97010 (Hot / Cold pack).

The denial is also **overturned** on all of the denied the CPT code(s) to include: 97750 (FCE), 99213 and 99214 (Office visit), 97110 (Therapeutic exercise), 97140 (Manual therapy technique), 95831 (Muscle test), 95851 (ROM) and 97012 (Mechanical traction).

The PHMO, Inc. physician reviewer has also determined to **uphold the denial** on the all of the denied CPT code(s) 96004 (Physician review of motion test) and the following CPT codes that occurred after 5.20.05 to include: 97032 (Electrical stimulation), 97035 (Ultrasound) and 97010 (Hot / Cold pack).

Summary of Clinical History

The claimant sustained a work related right shoulder injury on _____. An MRI confirmed the pathology. Surgery was done on the right shoulder on 12.12.03. The patient apparently had surgery again on the date of 3.9.04. There was a request for post surgical rehabilitation on 4.19.04. There was another request on 5.17.04 and on 6.14.04 from the surgeons to perform rehabilitation. Work hardening was recommended apparently on this date.

Clinical Rationale

The patient was post surgical during the time in question and all the rendering doctors including the surgeon recommended the care. The patient demonstrated various forms of improvement during the time in question as well. The review of motion testing should not be billed because all medical documentation is reviewed and is inclusive of services rendered. Passive modalities are really only reasonable for a short time period in the acute stage after the surgery. Functional testing was necessary to monitor outcomes. The service of physician review of motion testing is not supported.

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

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 Texas Department of Insurance /Division of Workers' Compensation. In accordance with the act and the rules, the review is listed on the DWC'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 the treating and/or referring 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.

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.

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 than 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. The address for the Chief Clerk of Proceedings would be: P.O. Box 17787, Austin, Texas, 78744.

I hereby verify that a copy of this Findings and Decision was faxed to Texas Department of Insurance /Division of Workers Compensation applicable to Commission Rule 102.5 this 21st day of December 2005. An amendment was requested done on 30th day of December, 2005. The Division of Workers Compensation will forward the determination to all parties involved in the case including the requestor, respondent and the injured worker.

Meredith Thomas
Administrator , Parker Healthcare Management Organization, Inc.