

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP () IE () IC	Response Timely Filed? (X) Yes () No
Requestor's Name and Address New Help Clinics 10300 North Central Expressway Dallas, Texas 75231	MDR Tracking No.: M5-05-1812-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address ISD Box 03	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
03-17-04	04-20-04	97140, 97124 and 97110	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
05-05-04, 06-09-04 and 06-28-04	05-05-04, 06-09-04 and 06-28-04	99213	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
03-17-04	04-20-04	99211 and 97112	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

PART III: 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 Commission Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Medical Review Division 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. The amount of reimbursement due from the carrier for the medical necessity issues equals **\$2,148.44**.

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 the Medical Review Division.

On 05-18-05, 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 codes 99213, 97140, 97124 and 97112 date of service 03-31-04 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for EOBs. Reimbursement is recommended as listed below:

99213 - \$62.81
97140 - \$26.04
97124 - \$21.71
97112 - \$35.26

Review of CPT codes 95831, 95851, 97140, 97124 and 97112 on date of service 04-26-04 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for EOBs. Reimbursement is recommended as listed below:

95831 - \$30.56
95852 - \$26.40
97140 - \$26.04
97124 - \$21.71
97112 - \$35.26

Review of CPT code 97110 on dates of service 03-31-04 and 04-26-04 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for EOBs., however, recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one". Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the maters in light of all of the Commission requirements for proper documentation. No reimbursement is recommended.

The total amount of reimbursement due from the carrier for the fee issues equals **\$285.79**.

PART IV: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to a refund of the paid IRO fee in the amount of **\$460.00**. The Division hereby **ORDERS** the insurance carrier to remit this amount and the appropriate amount for the services in dispute consistent with the applicable fee guidelines, plus all accrued interest due at the time of payment, to the Requestor within 20-days of receipt of this Order.

Ordered by:

Debra L. Hewitt

06-09-05

Authorized Signature

Typed Name

Date of Order

PART V: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____

PART VI: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

Phone: 512-402-1400

FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-05-1812-01
Name of Patient:	_____
Name of URA/Payer:	New Help Clinics, PA
Name of Provider: (ER, Hospital, or Other Facility)	New Help Clinics, PA
Name of Physician: (Treating or Requesting)	Gene Couturier, DC

June 6, 2005

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 Texas Workers' Compensation Commission 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: Texas Workers Compensation Commission

CLINICAL HISTORY

Items Reviewed:

1. Notification of IRO Assignment, Table of Disputed Services, Carrier EOBs
2. Right foot x-ray report, dated 12/16/01
3. Left ankle x-ray report, dated ____
4. Left ankle MRI report, dated 12/5/03
5. Initial examination and report, dated 3/8/04

6. Office notes and exercise logs from treating doctor, multiple dates
7. Peer review report, dated 3/21/04
8. Pain management referral doctor's report, dated 3/23/04, with a follow-up notes dated 5/4/04, 5/18/04
9. Orthopedic referral report, dated 3/26/04
10. Patient progress summary sheet and reexamination, dated 4/26/04
11. Rebuttal to peer review by the treating doctor, dated 5/5/04
12. Statement of position by treating doctor, dated 7/20/04
13. TWCC-73s

Patient is a 32-year-old female secretary for the independent school district who, on ____, injured her left ankle. Reportedly on that date, she was on a break and walked across the grass outside her office building. While walking, she stepped into a hold that she did not see and fell. She immediately reported the incident and presented herself to her family doctor who ordered approximately 1-2 weeks of passive therapies for ankle swelling, and then referred her to an orthopedist. An MRI was ordered that revealed a torn anterior talofibular ligament, but she was not thought to be a surgical candidate. She was placed in a knee high walking boot and released.

On 3/3/04, she received approval for a change of treating doctor and presented herself to a doctor of chiropractic. Following an examination on 3/8/04, she then received conservative chiropractic care to include both active and passive therapies. Despite the representation of significant improvement by the treating doctor of chiropractic, the pain management doctor referral diagnosed the patient with – and, began treating her for – RSD. He prescribed Neurontin and he opined that it was “imperative” a sympathetic blockade procedure be performed as soon as possible.

REQUESTED SERVICE(S)

Established patient office visits, levels I and III (99211 and 99213), manual therapy techniques (97140), massage therapy (97124), neuromuscular reeducation (97112), and therapeutic exercises (97110) for dates of service 3/17/04 through 6/28/04.

DECISION

The established patient office visits, level III (99213) for dates of service 5/5/04, 6/9/04 and 6/28/04 only are approved. In addition, the manual therapy techniques (97140), the massage therapies (97124), and the therapeutic exercise (97110) procedures are all approved.

All remaining services and procedures, including all level III office visits not specifically indicated above, are denied.

RATIONALE/BASIS FOR DECISION

The medical records in this case adequately documented that a compensable injury occurred to the patient's left ankle, so it was both appropriate and medically necessary that she receive a clinical trial of conservative chiropractic care, including physical therapy and rehabilitation. In addition, the records revealed that the statutory requirements¹ were met since the patient obtained relief, promotion of recovery was accomplished, and there was an enhancement of her ability to retain employment.

However, in terms of the level III office visits (99213) that were performed on 4/8/04 and 4/15/04, nothing in either the diagnosis or the medical records submitted for those dates of service supported the performance of this high a level of Evaluation and Management (E/M) service, particularly not during an already-established treatment plan. But for dates of service 5/5/04, 6/9/04 and 6/28/04, the medical records adequately supported that the treating doctor was integrally involved in the patient's case management with other providers at that time and during those visits, so this level of E/M service was appropriate as a function of proper coordination of care, per CPT.²

Insofar as the level I established patient office visits (99211) were concerned, the daily records were devoid of anything that suggested exactly what it was that was performed under this service. Since the documentation lacked any supporting rationale, the medical necessity for it was not supported.

¹ Texas Labor Code 408.021

² *CPT 2004: Physician's Current Procedural Terminology, Fourth Edition, Revised.* (American Medical Association, Chicago, IL 1999),

And finally, in regard to the neuromuscular reeducation services (97112), there was nothing in either the diagnosis or the physical examination findings on this patient that demonstrated the type of neuropathology that would necessitate the application of this service. According to a Medicare Medical Policy Bulletin ³, "This therapeutic procedure is provided to improve balance, coordination, kinesthetic sense, posture, motor skill, and proprioception. Neuromuscular reeducation may be reasonable and necessary for impairments which affect the body's neuromuscular system (e.g., poor static or dynamic sitting/standing balance, loss of gross and fine motor coordination, hypo/hypertonicity). The documentation in the medical records must clearly identify the need for these treatments." In this case, the documentation failed to fulfill these requirements, rendering the performance of this service medically unnecessary.

³ HGSA Medicare Medical Policy Bulletin, Physical Therapy Rehabilitation Services, original policy effective date 04/01/1993 (Y-1B)