

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: () HCP () IE () IC	Response Timely Filed? (X) Yes () No
Requestor's Name and Address Integra Specialty Group, P. A. 517 North Carrier Parkway, Suite G Grand Prairie, TX 75050	MDR Tracking No.: M5-05-2044-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address American Home Insurance Company, Box 19	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		
3-29-04	10-4-04	CPT codes 97110, 97140, 99213, 97012, 95831, 95833, 96004, 95851, 97750-FC	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input 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.

In accordance with Rule 133.308 (e) dates of service 3-15-04 through 3-19-04 are untimely and will not be a part of this review.

The Division has reviewed the enclosed IRO decision and determined that the requestor **prevailed** on the disputed medical necessity issues. The amount due the requestor for medical necessity services is \$2,898.04.

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. CPT codes 97110, 97140, 99213, 97012, 95831, 95833, 96004, 95851 and 97750-FC which were denied for medical necessity from 3-29-04 through 10-04-04 were found to be medically necessary. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 4-29-05 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.

CPT code 95831 on 4-29-04 was denied as "U693 – by clinical practice standards, this procedure is incidental to the related primary procedure billed." Per Ingenix Encoder Pro this service is a component procedure of CPT code 99213 which was billed on this date. The services represented by the code combination will not be paid separately. **Recommend no reimbursement.**

CPT code 95833 on 4-29-04 and 9-1-04 was denied as "U693 – by clinical practice standards, this procedure is incidental to the related primary procedure billed." Per Ingenix Encoder Pro this service is a component procedure of CPT code 99213 which was billed on this date. The services represented by the code combination will not be paid separately. **Recommend no reimbursement.**

CPT code 97799-CP (8 units) on 8-12-04 was denied as "F-the charge exceeds the fee schedule." Per Rule 134.202(e)(5)(E) reimbursement for CARF accredited Programs shall be \$125.00 per hour. Per Rule 134.202(d), reimbursement shall be the least of the (1) MAR amount as established by this rule or, (2) the health care provider's usual and customary charge). The requestor billed \$800.00. The insurance carrier reimbursed \$100.00. **Recommend additional reimbursement of \$700.00.**

Regarding CPT code CPT code 97799-CP on 10-4-04: This service was preauthorized. Neither the carrier nor the requestor provided EOB's. The req. submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). **Recommend reimbursement of \$800.00.**

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 the amount of \$4,398.04, plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Findings and Decision by:

_____	Donna Auby	6-30-05
Ordered by: _____	_____	_____
_____	Margaret Q. Ojeda	6-30-05
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 en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

Parker Healthcare Management Organization, Inc.

3719 N. Beltline Road, Irving, TX 75038
972.906.0603 972.255.9712 (fax)
Certificate # 5301

June 22, 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: M5-05-2044-01
RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 4.29.05.
- Fax request for provider records made on 4.29.05.
- TWCC issued Order for Payment on 5.11.05.
- The case was assigned to a reviewer on 6.01.05.
- The reviewer rendered a determination on 6.20.05.
- The Notice of Determination was sent on 6.22.05.

The findings of the independent review are as follows:

Questions for Review

The items in dispute are 97110, therapeutic exercise, 97140 manual therapy technique, 99213 occupational visit, 97012 mechanical traction, 95831 muscle testing extremity, 95833 muscle testing whole body, 96004 physician review and interpretation, 95851 ROM measurement and 97750-FC Functional capacity testing. All the aforementioned have been denied by the carrier as not medically necessary on the dates of 3.29.04 through the dates of 10.04.04. The denial is based upon EOB codes "V" and "U."

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 all dates of services submitted for IRO review. All care rendered during the period of time reviewed is medically appropriate.

Summary of Clinical History

Mr. ___ sustained a work related injury on ___, while employed with _____. He was injured while carrying cable that he was holding above his right shoulder. He stepped into a hole and twisted his left knee and injured his lower back. He has a history of surgery, conservative treatment and other forms of therapy and evaluations.

Clinical Rationale

The therapy up until the date of 10.04.04 is necessary based upon the review of the IDET post procedure care book offered for review, and the need for post procedure care as outlined by the rendering doctors. The provider offered medically appropriate care following Dr. Eaton's IDET procedure.

The FCE that followed the procedure was also appropriate. The patient did report to Dr. Eaton at the conclusion with a pain scale of 3.5/10. A functional assessment of the patient is appropriate considering the residual symptoms and the "sedentary" restrictions placed upon the patient by Dr. Eaton. Finally, the FCE apparently resulted in successful pre-certification of an Occ Rehab program.

The requestor's position is also supported by the designated doctor, who opined that the patient was not at MMI, and deserved additional care. This evaluation took place prior to the IDET.

The peer review that was used as a basis for the denial does not address the procedures and therapy in question. If a peer review were to be a denial factor in this case, it would have had to be performed after the IDET procedure was done, so that all of the specifics of the situation could have been taken into account. In this situation, there was a peer review done in August of 2003, long before the IDET was performed. It appears that this review was used as a basis to deny all future care, including this post-operative care. Furthermore, the reviewer offered a paper diagnosis of "back contusion." In light of the findings by Dr. Eaton and the Designated Doctor of Grade IV/V Annular Tear, the reviewer's opinions appear to be based upon an incorrect diagnosis. Reliance upon this peer review was inappropriate. The denial of these claims is completely without basis or logic, and should be overturned.

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 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.

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I hereby verify that a copy of this Findings and Decision was faxed to TWCC, Medical Dispute Resolution department applicable to Commission Rule 102.5 this 22nd day of June, 2005. The TWCC Medical Dispute Resolution department will forward the determination to all parties involved in the case including the requestor, respondent and the injured worker. Per Commission Rule 102.5(d), the date received is deemed to be 5 (five) days from the date mailed and the first working day after the date this Decision was placed in the carrier representative's box.

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.