



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
517 N. Carrier Parkway, Suite G
Grand Prairie, Texas 75050

MDR Tracking No.: M5-05-2086-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:
Texas Mutual
Box 54

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: TWCC-60, medical documentation, explanations of benefits, copy of preauthorization and CMS 1500's

POSITION SUMMARY: Medically necessary per Fee guidelines/documentation

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No response received

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
06-28-04 to 06-28-04	99213	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$68.24
05-18-04 to 11-24-04	99213	<input type="checkbox"/> Yes <input checked="" type="checkbox"/>	\$0.00
05-18-04 to 12-06-04	97012 (1 unit @ \$19.21 X 7 DOS) 97032 (2 units @ \$40.40 X 7 DOS) 97032 (1 unit @ \$20.20 X 6 DOS) 97110 (3 units @ \$110.97 X 6 DOS) 97140 (1 unit @ \$34.13 X 7 DOS) 97035 (1 unit @ \$15.84 X 3 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,490.72

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 majority** of the disputed medical necessity issues.

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 04-29-05, 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 97799 dates of service 04-12-04, 04-13-04 and 04-14-04 denied with denial code "A" (the treatment rendered exceeds the preauthorized treatment requested and/or approved)". Preauthorization was not obtained for the dates of service in dispute. No reimbursement recommended.

Review of CPT code 97012 (2 units) dates of service 05-04-04 and 05-11-04 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 the providers request for EOBs. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$38.42 (\$19.21 X 2 units)**.

Review of CPT code 97110 (6 units) dates of service 05-04-04 and 05-11-04 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 the providers request for EOBs. The requestor provided documentation to support the services in dispute. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$221.94 (\$110.97 X 2 DOS)**.

Review of CPT code 97140 (2 units) dates of service 05-04-04 and 05-11-04 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 the providers request for EOBs. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$68.26 (\$34.13 X 2 units)**.

Review of CPT code 99213 dates of service 05-04-04, 05-07-04 and 05-11-04 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 the providers request for EOBs. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$204.72 (\$68.24 X 3 DOS)**.

Review of CPT code 97010 date of service 05-07-04 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 the providers request for an EOB. CPT code 97010 per the 2002 Medical Fee Guideline is a bundled service code and considered an integral part of a therapeutic procedure(s). Regardless of whether it is billed alone or in conjunction with another therapy code, additional payment should not be made. No reimbursement recommended.

Review of CPT code 97032 (4 units) dates of service 05-07-04 and 05-11-04 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 the providers request for EOBs. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$80.80 (\$40.40 X 2 DOS)**.

Review of CPT code 97035 date of service 05-07-04 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 the providers request for an EOB. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$15.84**.

CPT code 99213 date of service 05-25-04 denied with denial codes “858/790/57” (physical medicine and rehabilitation services may not be reported in conjunction with an E/M code performed on the same day/charge was reduced in accordance to the Texas Medical Fee Guideline/payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, length of service, dosage or this day’s supply). The carrier not made a payment. Code 99213 is not global to other codes billed on the same date of service. The requestor submitted documentation to support the service in dispute. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$68.24**.

CPT code 99080-73 date of service 07-02-04 denied with denial code “F/TD” (Fee Guideline MAR reduction/the work status report was not properly completed). The requestor did not submit a copy of the TWCC-73 for review. No reimbursement recommended.

CPT code 99213 date of service 09-17-04 denied with denial code “F/N/MU” (Fee Guideline MAR reduction/not appropriately documented/physical medicine and rehabilitation services may not be reported in conjunction with an evaluation and management code performed on the same day. Code 99213 is not global to other codes billed on the same date of service. The requestor submitted documentation to support the service in dispute. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$68.24**.

CPT code 99213 date of service 10-01-04 denied with denial codes “245/287” (carrier is disputing the liability of claim or compensation of the injury/service denied because the doctor is not on the Texas Approved Doctors list (ADL) for date of service”. The compensability issues were resolved through a contested case hearing on 02-13-2004. The provider was on the ADL for the date of service in dispute. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$68.24**.

CPT code 95851 date of service 10-14-04 denied with denial codes “F/217” (Fee Guideline MAR reduction/the value of the procedure is included in the value of another procedure performed on this date). CPT code 95851 per the 2002 Medical Fee Guideline is global to CPT code 99213 billed on the same date of service. No reimbursement recommended.

CPT code 97140 date of service 10-29-04 denied with denial code “891” (the insurance company is reducing or denying payment after reconsidering a bill). Since neither party submitted a copy of the original explanation of benefits the review will be per Rule 134.202. Reimbursement is recommended in the amount of **\$34.13**.

CPT code 97110 (2 units) date of service 11-03-04 denied with denial code “F” (Fee Guideline MAR reduction). The carrier made a payment of \$34.46. The requestor submitted documentation supporting the service in dispute. Additional reimbursement per Rule 134.202(c)(1) is recommended in the amount of **\$39.52 (\$73.98 minus carrier payment of \$34.46)**.

CPT code 95833 date of service 11-05-04 denied with denial codes F/434” (Fee Guideline MAR reduction and the value of this procedure is included in the value of the mutual exclusive procedure). Per the 2002 Medical Fee Guideline CPT code 95833 is global to CPT code 99213 billed on the same date of service. No reimbursement recommended.

CPT code 97140 dates of service 11-01-04, 11-03-04, 11-05-04, 11-08-04, 11-10-04, 11-12-04, 11-15-04, 11-17-04, 11-19-04, 11-24-04 and 12-06-04 denied with denial codes “F/434” (Fee Guideline MAR reduction and the value of this procedure is included in the value of the mutual exclusive procedure). Per the 2002 Medical Fee Guideline CPT code 97140 is global to CPT code 97012 billed on all of the dates of service in dispute. No reimbursement recommended.

CPT code 96004 date of service 11-05-04 denied with denial code "F" (Fee Guideline MAR reduction). The carrier has made a payment of \$128.43. Additional reimbursement per Rule 134.202(c)(1) is recommended in the amount of **\$24.32**.

CPT code 97032 (1 unit) date of service 11-05-04 denied with denial code "F" (Fee Guideline MAR reduction). The carrier has made a payment of \$18.73. Additional reimbursement per Rule 134.202(c)(1) is recommended in the amount of **\$1.47 (\$20.20 minus carrier payment)**.

CPT code 97012 date of service 11-19-04 denied with denial codes "24/793" (payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan/reduction due to PPO contract). The requestor was contacted and verification was made that no PPO contract was in effect at the date of service. Reimbursement per Rule 134.202(c)(1) is recommended in the amount of **\$19.21**.

CPT code 95851 date of service 11-23-04 denied with denial code "G/435" (unbundling/the value of this procedure is included in the value of the comprehensive procedure). CPT code 95851 per the 2002 Medical Fee Guideline is global to 97140 billed on the same date of service. No reimbursement recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, Rules 134.202(c)(1) and 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 **\$2,444.07**.

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.

Ordered by:

09-30-05

Authorized Signature

Date of Findings and Decision and 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.

Parker Healthcare Management Organization, Inc.

4030 N. Bellline Road, Irving, TX 75038
972.906.0603 972.255.9712 (fax)
Certificate # 5301

September 20, 2005
Amended: September 29, 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: M5-05-2086-01
RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 7.27.05.
- Faxed request for provider records made on 7.29.05.
- TWCC issued an Order for Payment to the requestor on 8.10.05.
- The case was assigned to a reviewer on 9.5.05.
- The reviewer rendered a determination on 9.19.05.
- The Notice of Determination was sent on 9.20.05.
- TWCC requested amendment on 9.29.05.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of the following procedures: 97012 – mechanical traction, 97032 – electrical stimulation, 97110 – therapeutic exercises, 97140 – manual therapy technique, 97035 – ultrasound, 99213 office visits not marked as fee items from 05.07.04 through 12.06.04.

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 **uphold the denial** on the requested service(s): All 99213 office visits (except 06.28.04) are denied.

The PHMO, Inc. physician reviewer has also determined to **overturn the denial** on all other treatments and procedures, not specifically listed above, including:

5.18.04- 97012, 97032, 97110, 97140
5.25.04- 97012, 97110, 97140

6.03.04- 97012, 97032, 97110, 97140
6.28.04- 99213, 97012, 97110, 97140
7.06.04- 97012, 97032, 97110, 97140
7.12.04- 97012, 97032, 97110, 97140
7.23.04- 97012, 97140
11.05.04- 97032
11.12.04- 97035
11.15.04- 97032
11.17.04- 97032
11.19.04- 97032
11.22.04- 97035
11.23.04- 97032
11.24.04- 97032, 97035
12.03.04- 97032
12.06.04- 97032

Summary of Clinical History

Patient underwent physical medicine treatments, facet injections and discography after injuring his low back and right shoulder on ____, when he twisted while carrying a heavy load of debris.

Clinical Rationale

Based on CPT ¹, there is no support for the medical necessity for the high level 99213 E/M service on each and every visit during an established treatment plan. However, the office visit on 06.28.04 was appropriate since post surgical treatment was being initiated on that date of service.

Physical medicine is an accepted part of a rehabilitation program following surgical procedures. In this case, all of the remaining treatments (consisting of 97012 – mechanical traction, 97032 – electrical stimulation, 97110 – therapeutic exercises, 97140 – manual therapy technique, and 97035 – ultrasound), were indicated, appropriate and without question, medically necessary.

Clinical Criteria, Utilization Guidelines or other material referenced

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

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.

¹ CPT 2004: *Physician's Current Procedural Terminology, Fourth Edition, Revised.* (American Medical Association, Chicago, IL 1999),

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.

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 TWCC, Medical Dispute Resolution department applicable to Commission Rule 102.5 this 20th day of September, 2005. The determination was amended on the 29th day of September, 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.