

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## Retrospective Medical Necessity Dispute

### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (X) HCP ( ) IE ( ) IC	<b>Response Timely Filed?</b> ( ) Yes (X) No
Requestor's Name and Address Pain & Recovery Clinic C/O Bose Consulting, LLC P O BOX 550496 Houston, Texas 77255	MDR Tracking No.: M5-05-2247-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Employers Mutual Casualty 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		
05-17-04	07-26-04	97112, 99212 and 99214	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
			<input 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.

Per Rule 133.308(e)(1) dates of service 03-15-04 through 04-05-04 were not timely filed and will not be part of the review.

The Division has reviewed the enclosed IRO decision and determined that the requestor **did** prevail on the disputed medical necessity issues. The amount of reimbursement due from the carrier for the medical necessity issues equals **\$599.28**.

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.

Dates of service 03-15-04 through 04-05-04 were untimely filed per Rule 133.308(e)(1) and will not be a part of the review.

On 05-13-2005, 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.

CPT code 99214 date of service 05-07-04 denied with denial code "N" (not documented). The requestor submitted documentation, however, the documentation does not support delivery of service. No reimbursement recommended.

CPT code 99212 dates of service 05-07-04 and 05-10-04 denied with denial code "N" (not documented). The requestor submitted documentation that supported delivery of service for 05-07-04. The requestor did not submit documentation for date of service 05-10-04. Reimbursement is recommended per the requestor's billed amount of **\$48.03**.

CPT code 97032 dates of service 05-07-04, 05-10-04, 05-17-04, 05-20-04, 05-21-04, 05-26-04, 06-30-04, 07-06-04, 07-08-04, 07-22-04 and 07-26-04 denied with denial code "N" (not documented). The requestor submitted documentation for review for all dates of service with the exception of 05-10-04. The documentation supported delivery of service. Reimbursement is recommended in the amount of **\$200.40 (\$20.04 X 10 DOS)**.

CPT code 97140 dates of service 05-07-04, 05-10-04, 05-17-04, 05-20-04, 05-21-04, 05-26-04, 06-30-04, 07-06-04, 07-08-04, 07-22-04 and 07-26-04 denied with denial code "N" (not documented). The requestor submitted documentation for review for all dates of service with the exception of 05-10-04. The documentation supported delivery of service. Reimbursement is recommended in the amount of **\$339.10 (\$33.91 X 10 DOS)**.

CPT code 97112 dates of service 05-07-04, 05-10-04, 05-17-04, 05-20-04, 05-21-04, 07-06-04 and 07-26-04 denied with denial code "N" (not documented). The requestor submitted documentation for review for all dates of service with the exception of 05-10-04. The documentation supported delivery of service. Reimbursement is recommended in the amount of **\$220.50 (\$36.75 X 6 DOS)**.

CPT code 97110 dates of service 05-07-04, 05-10-04, 05-17-04, 05-20-04, 05-21-04, 05-26-04, 06-30-04, 07-06-04, 07-08-04, 07-22-04 and 07-26-04 denied with denial code "F" (Fee Guideline MAR reduction). 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 matters in light all of the Commission requirements for proper documentation. Reimbursement not recommended.

HCPCS code E1399 dates of service 05-17-04 and 05-26-04 denied with denial code "N" (not documented). The requestor submitted documentation, however, the documentation did not support the services billed. No reimbursement recommended.

HCPCS code E1399 dates of service 06-30-04, 07-22-04 and 07-26-04 denied with denial code "F" (Fee Guideline MAR reduction). Documentation submitted by the requestor did not support services billed. No reimbursement recommended.

**PART IV: COMMISSION DECISION**

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 totaling \$1,407.31 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.

Findings and Decision by:

\_\_\_\_\_  
Authorized Signature

07-19-05

\_\_\_\_\_  
Date of Decision

**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.**

**Parker Healthcare Management Organization, Inc.**  
3719 N. Beltline Road, Irving, TX 75038  
972.906.0603 972.255.9712 (fax)  
Certificate # 5301

July 8, 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: M5-05-2247-01  
RE: Independent review for \_\_\_\_

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

- Parker Healthcare Management received notification of independent review on 5.13.05.
- Faxed request for provider records made on 5.13.05.
- TWCC issued an Order for Records 5.27.05.
- The case was assigned to a reviewer on 6.21.05.
- The reviewer rendered a determination on 7.7.05.
- The Notice of Determination was sent on 7.8.05.

The findings of the independent review are as follows:

**Questions for Review**

The care that is currently in question and dispute are CPT codes 97112 (Neuromuscular re-e\_\_\_\_tion), 99212 and 99214 (Office visits). All being denied by the carrier due to the lack of medical necessity. The dates of service in dispute are: 5.17.04 through 7.26.04.

**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**. Approval of the aforementioned services in dispute, including all dates of neuromuscular re-education and office visits.

**Summary of Clinical History**

The aforementioned claimant is reported as sustaining a work related injury on \_\_\_\_\_. He was working construction when he stepped on a piece tile twisting his right knee.

**Clinical Rationale**

The claimant had surgery on the date of April 22, 2004. The care in dispute was rendered subsequent to the surgical procedure. Post-operative rehabilitation is universally accepted by any standard of care. The care did not fall into excess and the records indicate the patient benefited from the care. Therefore, the treatment does appear medical necessary.

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 a diplomate of the American Chiropractic Neurology Board, and serves as an Associate Professor with the Carrick Institute. 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.

#### 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 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 Tex. Admin. Code § 148.3). This Decision is deemed received by you 5 (five) days after it was mailed and the first working day after the date this Decision was placed in the carrier representative's box (28 Tex. Admin. Code § 102.5 (d)). A request for hearing should be sent to: Chief Clerk of Proceeding/Appeals , 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 this written request for a hearing to the opposing party involved in the dispute.

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 8<sup>th</sup> day of July, 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.

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Meredith Thomas  
Administrator  
Parker Healthcare Management Organization, Inc.