

# 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> (X) Yes ( ) No
Requestor's Name and Address  Pain and Recovery Clinic % Bose Consulting, L. L. C. P. O. Box 550496 Houston, Texas 77255	MDR Tracking No.: M5-05-2293-01
	TWCC 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: SUMMARY OF DISPUTE AND FINDINGS – DENIED FOR MEDICAL NECESSITY

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
4-26-04	10-01-04	CPT codes 99211 (except as noted below), 99212 (except as noted below), 99213, 97110, 97112, 98940, 97116, E1399	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
4-26-04, 5-19-04		CPT code 99212	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
6-21-04		CPT code 99211	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
4-26-04	5-10-04	CPT code 97032, 97035	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
5-11-04	10-01-04	CPT code 97032, 97035	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
4-26-04	6-21-04	CPT code 97110, 97140	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
6-22-04	10-01-04	CPT code 97110, 97140	<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 did **not** prevail on 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. CPT code 99212 on 4-26-04 and 5-19-04, CPT code 99211 on 6-21-05, CPT code 97032 and 97035 from 4-26-04 through 5-10-04, CPT codes 97110 and 97140 from 4-26-04 through 6-21-04 **were found** to be medically necessary. CPT code 99212 for all other dates of service, CPT code 99211 for all other dates of service, CPT codes 97032 and 97035 for all other dates of service, CPT codes 97110 and 97140 for all other dates of service, CPT code 97112, 98940, 97116 and E1399 for all dates of service **were not found** to be medically necessary. The amount of the medically necessary items is \$1,276.29. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 5-17-05 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.

Many EOB's from dates of service 5-5-04 through 10-30-04 were not provided by either the requestor or the respondent. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). The respondent's representative stated that the carrier had received all of the HCFA's. The respondent did not provide EOB's per rule 133.307(e)(3)(B).

**Recommend reimbursement per Rule 133.1(a)(8) as noted below:**

- CPT code 97035      \$205.14 - (\$15.78 13 units)
- CPT code 97112      \$801.90 - (\$36.45 X 22 units)
- CPT code 97140      \$135.64 - (\$33.91 X 4 DOS)
- CPT code 99212      \$480.30 - (\$48.03 X 10 DOS)
- CPT code 98940      \$ 66.64 - (\$33.32 X 2 DOS)
- CPT code 99032      \$140.28 - (\$20.04 X 7 DOS)
- CPT code 99214      \$104.79
- CPT code 99080-73   \$ 15.00
- CPT code 97018      \$17.28 - (\$8.64 X 2 DOS)
- CPT code 97150      \$157.78 - (\$22.54 X 7 units)

Regarding CPT code 97110 for dates of service 5-5-04 through 10-30-04: 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. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Additional reimbursement not recommended.

Regarding CPT code 97799 for dates of service 10-5-04 through 10-25-04: Per Rule 134.600(h) chronic pain management requires preauthorization. The requestor has not provided proof of preauthorization. Recommend no reimbursement.

CPT code 99080-73 on 5-19-04, 6-16-04 and 8-25-04 was denied by the carrier with a "V" for unnecessary medical treatment based on a peer review; however, the TWCC-73 is a required report per Rule 129.5 and is not subject to an IRO review. A referral to Compliance and Practices will be made for this violation by the carrier. The Medical Review Division has jurisdiction in this matter. **Recommend reimbursement of \$45.00 (\$15.00 X 3 DOS).**

**PART IV: COMMISSION DECISION**

The Division hereby **ORDERS** the insurance carrier to remit the amount of \$3,446.04, 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	7-14-05
Ordered by:	Margaret Q. Ojeda	7-14-05
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.

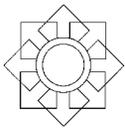
Signature of Insurance Carrier: \_\_\_\_\_ Date: \_\_\_\_\_

**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.**



# Texas Medical Foundation

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## NOTICE OF INDEPENDENT REVIEW DECISION

June 28, 2005

Program Administrator  
Medical Review Division  
Texas Workers Compensation Commission  
7551 Metro Center Drive, Suite 100, MS 48  
Austin, TX 78744-1609

RE: Injured Worker: \_\_\_\_\_  
MDR Tracking #: M5-05-2293-01  
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. TMF's health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

### Clinical History

This 32 year-old male injured his left shoulder on \_\_\_\_ when a scaffold fell onto him at his place of employment. He has been treated with therapy, medications and surgery.

### Requested Service(s)

Office visits, therapeutic exercises, electric stimulation (manual), ultrasound, manual therapy technique, neuromuscular re-education, chiropractic manipulative, treatment-spinal, gait training, and durable medical equipment

### Decision

It is determined that there is no medical necessity for the neuromuscular re-education, chiropractic manipulative treatment-spinal, gait training, and durable medical equipment for dates of service 04/26/04 through 10/01/04 to treat this patient's medical condition.

It is determined that there is medical necessity for the office visits (99212) for dates of service 04/26/04 and 05/19/04. Office visit (99211) on 06/21/04 is also medically necessary. All other office visits (99212, 99211 and 99213) are not medically necessary to treat this patient's medical condition for dates of service 04/26/04 through 10/01/04 except those listed above.

It is determined that there is medical necessity for the electric stimulation (manual) and ultrasound for dates of service 04/26/04 through 05/10/04 to treat this patient's medical condition. There is no medical necessity for the electric stimulation (manual) and ultrasound for dates of service 05/11/04 through 10/01/04 to treat this patient's medical condition.

It is determined that there is medical necessity for the therapeutic exercises and manual therapy technique for dates of service 04/26/04 through 06/21/04 to treat this patient's medical condition. There is no medical necessity for the therapeutic exercises and manual therapy technique for dates of service 06/22/04 through 10/01/04 to treat this patient's medical condition.

#### Rationale/Basis for Decision

Medical record documentation does not indicate the need for neuromuscular re-education as there is no neuropathology injury indicated. There is no medical documentation explaining the need for chiropractic manipulative therapy to the spine for a post surgical shoulder injury and documentation does not indicate a need for gait training or durable medical equipment. Therefore, the neuromuscular re-education, chiropractic manipulative treatment-spinal, gait training, and durable medical equipment for dates of service 04/26/04 through 10/01/04 are not medically necessary to treat this patient's medical condition.

It is expected that 2 weeks of passive treatment followed by 6 weeks of active rehabilitation would be medically necessary. Specified treatments during those time periods are medically necessary to treat this patient's medical condition. However, medical record documentation does not indicate the necessity for treatment beyond those time frames nor does it fulfill statutory requirements<sup>1</sup> for medical necessity. The patient obtained no significant relief, promotion of recovery, and there was no enhancement of the employee's ability to return to work. Therefore, the office visits (99212) for dates of service 04/26/04 and 05/19/04 and office visit (99211) for date of service 06/21/04 is medically necessary. All other office visits (99212, 99211 and 99213) are not medically necessary. Electric stimulation (manual) and ultrasound for dates of service 04/26/04 through 05/10/04 is medically necessary; however, not medically necessary for dates of service 05/11/04 through 10/01/04. Finally, the therapeutic exercises and manual therapy technique for dates of service 04/26/04 through 06/21/04 is medically necessary; however, the dates of service 06/22/04 through 10/01/04 is not medically necessary to treat this patient's medical condition.

Sincerely,



Gordon B. Strom, Jr., MD  
Director of Medical Assessment

GBS:vn

Attachment

**Information Submitted to TMF for TWCC Review**

**Patient Name:** \_\_\_\_

**TWCC ID #:** M5-05-2293-01

**Information Submitted by Requestor:**

- Position Statement
- Progress Notes
- Diagnostic Tests
- Functional capacity evaluation
- Impairment Rating
- Psychodiagnostic Evaluation

**Information Submitted by Respondent:**

- Claims
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