

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 Pain and Recovery Clinic of North Houston % Constance Wheat 6660 Airline Dr. Houston, Texas 77076	MDR Tracking No.: M5-05-2346-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Indemnity Insurance Company - SRS, Box 15	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS – MEDICAL NECESSITY ISSUES

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
7-19-04	11-30-04	CPT codes 97110, 97140, 97112, 99212	<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.

On 5-25-05 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.

Regarding CPT code 99212 on 10-19-04: Neither the carrier nor the requestor provided EOB's. The requestor 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 \$48.03.

Regarding CPT code 97110 on 10-19-04: Neither the carrier nor the requestor provided EOB's. The requestor 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). 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. Reimbursement not recommended.

Regarding CPT code 97140 on 10-19-0 (2 units): Neither the carrier nor the requestor provided EOB's. The requestor 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 \$67.80.

Regarding CPT code 97112 on 10-19-04, 11-16-04, and 11-22-04: Neither the carrier nor the requestor provided EOB's. The requestor 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 \$110.07 (36.69 X 3 DOS).

CPT code 97110 on 11-5-04, 11-8-04, 11-10-04 and 11-11-04 was denied as "G - Unbundling." 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. Reimbursement not recommended.

CPT code 97140 (2 units each date) on 11-05-04, 11-8-04, 11-10-04 and 11-11-04 was denied as "G" - Unbundling." Per the 2002 MFG this code is not global to any other procedures on this date of service. Recommend reimbursement of \$271.20 (67.80 X 4 DOS).

CPT code 97112 on 11-05-04, 11-8-04, 11-10-04 and 11-11-04 was denied as "G - Unbundling." Per the 2002 MFG this code is not global to any other procedures on this date of service. Recommend reimbursement of \$146.76 (\$36.69 X 4 DOS).

CPT code 99212 on 11-8-04, 11-10-04 and 11-11-04 was denied as "G - Unbundling." Per the 2002 MFG this code is not global to any other procedures on this date of service. Recommend reimbursement of \$144.09 (\$48.03 X 3 DOS).

PART IV: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to a refund of the paid IRO fee. The Division hereby **ORDERS** the insurance carrier to remit the appropriate amount for the services in dispute consistent with the applicable fee guidelines totaling \$787.95, 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

8-25-05

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

If you are unhappy with all or part of this decision, you have the right to appeal the decision. Those who wish to appeal decisions that were issued during the month of August 2005, should be aware of changes to the appeals process which take effect September 1, 2005.

House Bill 7, recently enacted by the 79th Texas Legislature, provides that an appeal of a medical dispute resolution order that is not pending for a hearing at the State Office of Administrative Hearings (SOAH) on or before August 31, 2005 is not entitled to a SOAH hearing. This means that the usual 20-day window to appeal to SOAH, found in Commission Rule 148.3, will be shortened for some parties during this transition phase. If you wish to seek an appeal of this medical dispute resolution order to SOAH, you are encouraged to have your request for a hearing to the Commission as early as possible to allow sufficient time for the Commission to submit your request to SOAH for docketing. A request for a SOAH 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.

Beginning September 1, 2005, appeals of medical dispute resolution 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.

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



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NOTICE OF INDEPENDENT REVIEW DECISION

August 18, 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 #: M5-05-2346-01
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 §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 TMF physician reviewer who is board certified in Family Practice which is the same specialty as the treating physician, provides health care to injured workers, and licensed by the Texas State Board of Medical Examiners in 1997. The TMF physician reviewer 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 43 year-old male injured his left knee, right ankle and back on ____ while pushing a large garbage bin. He slipped, twisted his knee and fell. He has been treated with medications and therapy.

Requested Service(s)

Therapeutic exercises for dates of service 07/19/04 through 11/30/04 (dates of service 11/05/04, 11/08/04, 11/10/04, 11/11/04 not reviewed)

Manual therapy technique 07/19/04 through 11/30/04 (dates of service 11/05/04, 11/08/04, 11/10/04, 11/11/04 not reviewed)

Neuromuscular re-education 07/19/04 through 11/30/04 (dates of service 11/05/04, 11/08/04, 11/10/04, 11/11/04, 11/16/04, 11/22/04 not reviewed)

Office visit 07/19/04 through 11/30/04 (dates of service 10/19/04, 11/05/04, 11/08/04, 11/10/04, 11/11/04 not reviewed)

Decision

It is determined that there is no medical necessity for the therapeutic exercises for dates of service 07/19/04 through 11/30/04 (dates of service 11/05/04, 11/08/04, 11/10/04, and 11/11/04 not reviewed), manual therapy technique 07/19/04 through 11/30/04 (dates of service 11/05/04, 11/08/04, 11/10/04, and 11/11/04 not reviewed), neuromuscular re-education 07/19/04 through 11/30/04 (dates of service 11/05/04, 11/08/04, 11/10/04, 11/11/04, 11/16/04, and 11/22/04 not reviewed), and office visits 07/19/04 through 11/30/04 (dates of service 10/19/04, 11/05/04, 11/08/04, 11/10/04, and 11/11/04 not reviewed) were not medically necessary to treat this patient's medical condition.

Rationale/Basis for Decision

Medical record documentation indicates this patient was treated with various types of therapy. Expectation of improvement in a patient's condition should be established based on success of treatment. Continued treatment is expected to improve the patient's condition and initiate restoration of function. If treatment does not produce the expected positive results, it is not reasonable to continue that course of treatment. In this case, medical record documentation does not indicate an objective or functional improvement in this patient's condition and no evidence of a change of treatment plan to justify additional treatment in the absence of positive response to prior treatment. Therefore, the therapeutic exercises, manual therapy technique and neuromuscular re-education for the dates of service in question is not medically necessary to treat this patient's medical condition.

Additionally, for an established patient, there is no need for an office visit at this level of care for each and every visit. Therefore, the office visits for the dates of service in question are not medically necessary to treat this patient's medical condition.

Sincerely,



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

GBS:dm

Attachment

Information Submitted to TMF for TWCC Review

Patient Name: ____

TWCC ID #: M5-05-2346-01

Information Submitted by Requestor:

- Requestor's Position
- Progress Notes
- Independent Medical Examination
- Peer Review
- Diagnostic Tests
- Designated Doctors Evaluation
- Claims

Information Submitted by Respondent:

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