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 James Todd Boyd, D. C. 2310 N. Expressway 83 Brownsville, TX 78526	MDR Tracking No.: M5-05-2413-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address TX Municipal League Workers, 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**		
5-10-04	**10-27-04**	**CPT codes 97012, G0283, 97039, 97110, 97112, 97124,98940, 97140, 99631,99214**	☒ **Yes** ☐ **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 **prevailed** on the disputed medical necessity issues. The total amount due the Requestor for the medical necessity services is $1,266.44.

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.

On 10-13-05 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 99070 (ice pack) on 5-10-04 was denied as "F – fee guideline MAR reduction." When billing the services for which the Commission has not established a maximum allowable reimbursement, per Rule 133.307(g)(3)(D), the requestor is required to discuss, demonstrate and justify that the payment being sought is a fair and reasonable rate of reimbursement. The Requestor has not provided sample EOBs or other evidence that the fees billed are for similar treatment of injured individuals and that reflect the fee charged to and paid by other carriers. **Recommend no reimbursement.**

CPT code 99070 (Baldrain and Inflamax) were denied by the carrier as "M – No MAR". When billing the services for which the Commission has not established a maximum allowable reimbursement, per Rule 133.307(g)(3)(D), the requestor is required to discuss, demonstrate and justify that the payment being sought is a fair and reasonable rate of reimbursement. The Requestor has not provided sample EOBs or other evidence that the fees billed are for similar treatment of injured individuals and that reflect the fee charged to and paid by other carriers. **Recommend no additional reimbursement**.

CPT code G0283 on 5-18-04, 5-19-04, 5-20-04, 5-21-04, 5-24-04, 6-9-04 and 6-21-04 was denied as "F – fee guideline MAR reduction." The carrier made no payment and gave no valid reason for not doing so. **Recommend reimbursement per Commission Rule 133.1(a)(8) of $93.84 ($13.41 X 7 DOS).**

CPT code 97112 on 6-2-04 was denied as "F – fee guideline MAR reduction." The carrier made no payment and gave no valid reason for not doing so. **Recommend reimbursement per Commission Rule 133.1(a)(8) of $34.30.**

CPT code G0283, 97012, 97039, 97112 and 98940 on 7-7-04 was denied as "F – fee guideline MAR reduction." An "allowed fee" was recommended by the carrier. The carrier made no payment and gave no valid reason for not doing so. **Recommend reimbursement per Commission Rule 133.1(a)(8) as follows:**

G0283 - $13.41
97012 - $17.91
97039 - $13.93
97112 - $34.30
98940 - $31.35

Regarding CPT code 97110 on 7-7-04: 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. **Reimbursement not recommended.**

Regarding CPT code 99080-73 on 8-20-04, 8-30-04 and 9-30-04: The carrier denied CPT Code 99080-73 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 will be made to Compliance and Practices for this violation. The Medical Review Division has jurisdiction in this matter; **Recommend reimbursement of $45.00 ($15.00 X 3 DOS).**

Regarding CPT code 99080-73 on 10-27-04: The carrier denied this service as "F – fee guideline MAR reduction." The carrier made no payment and gave no valid reason for not doing so. Recommend reimbursement per Commission Rule 133.1(a)(8) of **$15.00.**

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 $1,565.48, plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

		7-8-05
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.

July 1, 2005

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

RE: Medical Dispute Resolution
MDR#: M5-05-2413-01
TWCC#:
Injured Employee:
DOI: 05/___/04

IRO Cert. #: IRO5055

Dear Ms. :

IRI has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc. and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the independent review organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is licensed chiropractor, and is currently on the TWCC Approved Doctor List.

Sincerely

REVIEWER'S REPORT
M5-05-2413-01

Information Provided for Review:
TWCC-60, Table of Disputed Services, EOBs
Information provided by Requestor:

Office notes 05/10/04 – 11/08/04
Physical therapy notes 05/10/04 – 11/08/04
FCE 07/16/04
Nerve conduction study 05/25/04
Radiology reports 05/10/04 – 05/14/04

Information provided by Respondent:
Designated doctor review

Information from Pain Management Specialist:
Office notes 05/18/04 – 07/13/04

Information from Neurosurgeon:
Office note 06/17/04

Clinical History:
Patient underwent physical medicine treatments, FCE, NCV and diagnostic imaging after sustaining injury to her lumbar spine while pushing a box at work on 05/07/04.

Disputed Services:
Mechanical traction, electrical stimulation, modality passive motion, therapeutic exercises, neuromuscular re-education, massage therapy, chiropractic manipulative treatment-spinal, manual therapy technique, medical conference physician w/team coordinator, and office visits during the period of 05/10/04 thru 10/27/04

Decision:
The reviewer disagrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were medically necessary in this case.

Rationale:
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. With documentation of improvement in the patient's condition and restoration of function, continued treatment may be reasonable and necessary to effect additional gains.

In this case, there is adequate documentation of objective and functional improvement in this patient's condition. In fact, the medical records fully substantiate that the disputed services fulfilled statutory requirements (Texas Labor Code 408.021) for medical necessary since the patient obtained relief (without surgery), promotion of recovery was accomplished and the employee returned to full employment.