THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-05-9255.M5

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP ( ) IE ( ) IC	**Response Timely Filed?** ( ) Yes (X) No
Requestor's Name and Address Jack P. ___, D.C. P O BOX 9159 Longview, Texas 75608-9159	MDR Tracking No.: M5-05-2426-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Texas Mutual Insurance Company Box 54	Date of Injury: Employer's Name: Insurance Carrier's No.: 99E0000376684

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	**To**		
05-05-04	**02-15-05**	**A4556, 97112, 99214, 97110, 97530, 98941, G0283, 97012 and 99371**	☒ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**
			☐ **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 **did** prevail on the disputed medical necessity issues. The amount due from the carrier for the medical necessity issues equals **$4,761.96.**

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 06-10-05, 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.

Review of CPT code 72110-WP date of service 05-05-04 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. The carrier has made a payment of $34.36. Additional reimbursement for code 72110-WP is recommended in the amount of **$25.40 ($47.89 X 125% = $59.86 minus carrier payment).**

Review of CPT code 97540 date of service 05-11-04 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, however per the 2002 Medical Fee Guideline code 97540 is a deleted code. No reimbursement is recommended.

CPT code 97112 dates of service 05-06-04, 05-07-04, 05-08-04, 05-10-04, 05-11-04, 05-13-04, 05-14-04 and 05-17-04 denied with denial code "G" /Z3 (global/the procedure which is the component code is considered integral to the successful completion of the comprehensive procedure. The procedure does not represent a separately identifiable unrelated procedure). Per Rules 133.304(c) and 134.202(a)(4) the carrier did not specify which code 97112 was global to. Reimbursement is recommended in the amount of **$274.40 ($34.30 X 8 DOS).**

CPT code 99080-73 dates of service 08-02-04 and 09-03-04 denied with denial code "U" (unnecessary medical without peer review). Per Rule 129.5 the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. Reimbursement is recommended in the amount of **$30.00.** A Compliance and Practices referral will be made as the carrier is in violation of Rule 129.5.

CPT code 99080 date of service 08-03-04 denied with denial code "N" (not documented). The requestor submitted documentation to support the delivery of the service billed per Rule 133.307(g)(3)(A-F). Reimbursement is recommended in the amount of **$4.00.**

CPT code 97012 date of service 08-23-04 denied with denial code "F" (Fee Guideline MAR reduction). The carrier has made no payment. Reimbursement per Rule 134.202(c)(1) is recommended in the amount of **$17.91.**

CPT code 98941 dates of service 09-10-04, 09-15-04, 09-22-04, 09-29-04, 10-11-04 and 10-18-04 denied with denial code "F/793" (Fee Guideline MAR reduction/Reduction due to PPO Contract). The carrier has made a payment of $206.40. The requestor did not provide proof that a contract does not exist. No additional reimbursement is recommended.

CPT code 97012 dates of service 09-15-04, 09-22-04, 09-29-04 and 10-11-04 denied with denial code "F/793" (Fee Guideline MAR reduction/Reduction due to PPO Contract). The carrier has made a payment of $57.32. The requestor did not provide proof that a contract does not exist. No additional reimbursement is recommended.

CPT code 99214-MP date of service 11-29-04 denied with denial code "973" (payment denied as this modifier is incorrect or no longer valid. Per the 2002 Medical Fee Guideline the modifier MP is not valid. No reimbursement is recommended.

CPT code 99371 date of service 11-29-04 denied with denial code "G" (global). Case management in the Texas Workers compensation system consists of either team conferences or telephone calls with an interdisciplinary team that may include the employer. Although the treating doctor is primarily responsible for case management, a referral provider, such as a physical therapist or surgeon to whom the injured worker has been referred, may initiate communication, bill and be reimbursed for case management. The requestor supplied documentation to support the services billed. Reimbursement is recommended in the amount of **$11.00** per the 2002 Medical Fee Guideline.

CPT code 99080 date of service 12-01-04 denied with denial code "F/217" (Fee Guideline MAR reduction/the value of this procedure is included in the value of another procedure performed on this date). Per Rules 133.304(c) and 134.202(a)(4) the carrier did not specify which code 99080 was included in the value of. Reimbursement is recommended in the amount of **$59.50.**

CPT code 99455-VR dates of service 12-09-04 and 12-29-04 denied with denial code "C"/793" (reduction due to PPO contract). The carrier made a payment of $80.00. The requestor did not provide proof that a contract does not exist. No additional reimbursement is recommended.

CPT code 99080 (copies of records) date of service 12-13-04 denied with denial code "F217" (Fee Guideline MAR reduction/the value of this procedure is included in the value of another procedure performed on this date). Per Rules 133.304(c) and 134.202(a)(4) the carrier did not specify which code 99080 was included in the value of. Reimbursement is recommended in the amount of **$63.00.**

Review of CPT code G0283 date of service 02-14-05 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)2(A) the requestor is required to submit "a copy of all medical bill(s) as originally submitted to the carrier for reconsideration". No HCFA was submitted for review by the requestor. No reimbursement is 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 in dispute totaling $5,247.17 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:

		07-26-05
Authorized Signature		Date of Decision

Order by:

	07-26-05
Authorized Signature	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.

MEDICAL REVIEW OF TEXAS

[IRO #5259]
3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	___
MDR Tracking Number:	M5-05-2426-01
Name of Patient:	___
Name of URA/Payer:	Texas Mutual Insurance Company
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Jack P. Mitchell, DC

July 12, 2005

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Texas Workers Compensation Commission

CLINICAL HISTORY

Mr. ___, a 64-year-old male, was involved in a work-related injury to his low back that occurred while attempting to prevent a refrigerator falling. The patient attempted to catch and restrain the refrigerator from toppling over, and in so doing strained his lower back. He presented to Dr. Mitchell, who placed him on a comprehensive conservative treatment regime consisting of manipulation with adjunctive physiotherapeutic modalities progressing to more active interventions. MRI was obtained on 7/28/04 revealing degenerative disc disease throughout the lumbar spine, a transitional vertebra at L5-S1, with central protrusion at L4/L5, indenting the thecal sac. A second orthopedic opinion was obtained from Dr. Shade, who felt the patient would benefit from some local he assigns as well as ongoing PT. The recommendation for injections was declined by the patient.

The patient remained at work as a merchandising vendor on modified duty, maintained with lifting restrictions. He was referred for MMI/impairment rating purposes to Dr. Huggins and 12/6/04, and was determined to be at MMI with a 5% DRE II category in the lumbar spine.

REQUESTED SERVICE(S)
Medical necessity of electrodes (A4556), neuromuscular reeducation (97112), office visit (99214), therapeutic exercises (97110), therapeutic activities (97530), chiropractic manipulation (98941), electrical stimulation (G0283), mechanical traction (97012), telephone call by Dr. to patient (99371); Service dates 05/05/04 - 2/15/05

DECISION
Approve.

RATIONALE/BASIS FOR DECISION
The standard of medical necessity in Workers Comp, according to the Texas labor code 408.021 (entitlement to medical benefits) is that an

employee who sustained a compensable injury is entitled to all healthcare reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to healthcare that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment.

Unfortunately, there is no rationale offered by the carrier as to why it feels the services were not medically necessary. In contrast, the treating doctor makes that he strong case for medical necessity in his request for reconsideration, and this is supported by the documentation.

The initial evaluation and subsequent treatment notes substantiate a lumbar spine injury, with subsequent improvement obtained with treatment rendered. The treatment rendered satisfies the above-mentioned standard for medical necessity according to the Texas labor code, and are within accepted clinical practice guidelines.

The above analysis is based solely upon the medical records/tests submitted. It is assumed that the material provided is correct and complete in nature. If more information becomes available at a later date, an additional report may be requested. Such and may or may not change the opinions rendered in this evaluation.

Opinions are based upon a reasonable degree of medical/chiropractic probability and are totally independent of the requesting client.

References:

Hansen DT: Topics in Clinical Chiropractic, 1994, volume one, No. 4, December 1994, pp. 1-8 with the article "Back to Basics: Determining how much care to give and reporting patient progress".

Haldeman S., Chapman-Smith D, Peterson DM., eds. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen: Giathersburg, MD, 1993;

Souza T: Differential Diagnosis for a Chiropractor: Protocols and Algorithms, 1997; chapter 1, pp. 3-25.

Liebenson C. Commentary: Rehabilitation and chiropractic practice. JMPT 1996; 19(2):134140