

# 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  <b>Health and Medical Practice</b> <b>324 N. 23<sup>rd</sup> St. Ste #201</b> <b>Beaumont, TX 77707</b>	MDR Tracking No.:                      M5-05-2477-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address  <b>TX Mutual Insurance Company, Box 54</b>	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

### PART II: SUMMARY OF DISPUTE AND FINDINGS – MEDICAL NECESSITY ITEMS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
7-22-04	9-15-04	CPT codes 97035, 97140, 97032, 95900	<input checked="" 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.

The Division has reviewed the enclosed IRO decision and determined that the requestor **prevailed** on the disputed medical necessity issues. The amount due the requestor for the medical necessity issues is \$705.01.

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 6-24-05 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 97035 (2 units) on 7-23-04 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 134.202(c)(1) of \$37.46 (\$18.73 x 2 units).**

CPT code 97140 on 7-23-04 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 134.202(c)(1) of \$31.73.**

CPT code 97110 (3 units) on 7-23-04 was denied as "F – fee guideline MAR reduction." The carrier made no payment and gave no valid reason for not doing so. 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 97032 on 9-22-04 (2 units) 9-23-04 (2 units) 9-24-04 (2 units), 9-27-04 (2 units), 9-30-04 (2 units), 10-5-04 (2 units) 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 134.202(c)(1) of \$187.30 (\$18.73 X 10 units).**

CPT code 97530 on 9-22-04 (2 units) 9-27-04 (2 units) 9-30-04 (2 units) and 10-5-04 (2 units) 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 134.202(c)(1) of \$277.20 (\$34.65 X8 units).**

CPT code 97124 on 9-22-04, 9-30-04 and 10-5-04 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 134.202(c)(1) of \$78.84 (\$26.28 X 3 DOS).**

**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 \$650.00. The Division hereby **ORDERS** the insurance carrier to remit the amount of \$1,317.54, plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Donna Auby

8-2-05

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 en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**

July 29, 2005

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

Re: Medical Dispute Resolution  
MDR #: M5-05-2477-01  
TWCC#: \_\_\_\_\_  
Injured Employee: \_\_\_\_\_  
DOI: \_\_\_\_\_  
SS#: \_\_\_\_\_  
IRO Certificate No.: IRO 5055

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 board certified in Physical Medicine & Rehabilitation and in Pain Medicine, and is currently on the TWCC Approved Doctor List.

Sincerely,

Gilbert Prud'homme  
General Counsel

GP:thh

**REVIEWER'S REPORT**  
**M5-05-2477-01**

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**Information Provided for Review:**

TWCC-60, Table of Disputed Services, EOB's  
Information provided by Requestor:

Correspondence  
Office notes 07/21/04 – 06/01/05  
Daily progress notes 07/22/04 – 10/05/04  
Physiotherapeutic notes 07/21/04 – 10/05/04  
FCE 07/28/04 – 09/28/04  
Nerve conduction studies 07/23/04 – 09/23/04  
Radiology reports 07/22/04 – 10/04/04

Information provided by Respondent:

Designated doctor reviews

Information provided by Spine Surgeon:

Office notes 02/04/05 – 04/08/05

**Clinical History:**

This male patient suffered a right shoulder injury at work on \_\_\_\_\_. He underwent physical therapy including ultrasound, manual therapy, electrical stimulation. He also had nerve conduction testing. Functional capacity evaluations were done in July and September, 2004.

**Disputed Services:**

Ultrasound, manual therapy technique, electrical stimulation-manual, and nerve conduction test during the period of 07/22/04 thru 09/15/04.

**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:**

The medical care for this injured worker was appropriate. A trial of conservative care is advisable with this type of injury. The manual therapy, electrical stimulation, ultrasound and nerve conduction evaluations were well within the bounds of appropriate conservative therapy. Of interest is that the review by Dr. Kirkwood of 10-07-04, actually calls for further physical therapy.