



Texas Department of Insurance, Division of Workers' Compensation  
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

## MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

### Retrospective Medical Necessity and Fee Dispute

#### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address:	MDR Tracking No.: M5-05-2483-01
Summit Rehabilitation Centers 2500 W. Freeway #200 P.O. Box 380395 Ft. Worth, TX 76102	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:
Zurich American Insurance Company, Box 19	

#### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included TWCC 60 form, Explanations of Benefits, medical documentation and CMS 1500's. Position summary stated, "Per the MFG, reimbursement for services is dependent on the accuracy of the coding and documentation. All participants shall be responsible for correctly applying the ground rules contained within the MFG and the rules contained within the CPT/HCPCS and the ICD-9-CM coding system."

#### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included TWCC 60 form, Explanations of Benefits, medical documentation and CMS 1500's. The position summary states, "Dates of Service 5-11-04 – 5-13-04 were untimely filed. All treatments were neither reasonable or necessary."

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
5-21-04 and 5-28-04	CPT code 99213	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$136.48
6-25-04 – 8-20-04	CPT code 99213	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0

#### PART V: 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 Division Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), Medical Dispute Resolution 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 majority of the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$136.48.

Based on review of the disputed issues within the request, the 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 Medical Dispute Resolution.

On 8-10-05 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.

Dates of service 5-11-04 and 5-13-04 were untimely filed. In accordance with Rule 133.308 (e) these items will not be reviewed by the Division.

CPT code 99213 on 6-4-04 was withdrawn by the requestor and will not be a part of this review.

CPT code 99090 was denied as "G-global". Per Medicare this is a bundled code. Recommend no reimbursement.

The carrier denied CPT Code 99080-73 on 6-18-04 and 7-19-04 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. The Medical Review Division has jurisdiction in this matter; Recommend reimbursement of \$30.00 (\$15.00 X 2 DOS).

Regarding CPT code 99080-73 on 8-18-04: 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 \$15.00.

Regarding CPT code 99082 on 8-13-04: Per Rule 134.6 travel issues are not handled in Medical Dispute Resolution. This is a Field Office issue.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. 133.308 and 134.6.

**PART VII: DIVISION DECISION**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the requestor is not entitled to a refund of the paid IRO fee. The Division has determined that the requestor is entitled to reimbursement in the amount of \$181.48. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30 days of receipt of this Order.

Findings and Decision and Order by:

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Typed Name

10-14-05

\_\_\_\_\_  
Date of Order

**PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW**

Appeals of medical dispute resolution decisions and 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. The Division is not considered a party to the appeal.

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

September 27, 2005

September 9, 2005

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

**CORRECTED REPORT**

Re: Medical Dispute Resolution  
MDR #: M5-05-2483-01  
TWCC#: \_\_\_\_\_  
Injured Employee: \_\_\_\_\_  
DOI: \_\_\_\_\_  
SS#: \_\_\_\_\_  
IRO Certificate No.: IRO 5055

Dear \_\_\_\_\_:

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 in chiropractic, and is currently on the TWCC Approved Doctor List.

Sincerely,

Gilbert Prud'homme  
General Counsel

GP:dd

**REVIEWER'S REPORT**  
**M5-05-2483-01**

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**Information Provided for Review:**

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor:

Medical Necessity Letter

Office Notes 05/11/04 – 08/20/04

Information provided by Respondent:

Correspondence

Designated Reviews

**Clinical History:**

The records indicate that the patient was injured on the job on \_\_\_ while working. While mopping, she tripped over an appliance power cable, falling into a service table with her left arm outstretched, causing her injuries. At the time of injury, she was 6 months pregnant. She felt immediate pain in her left arm, low back, neck, and left hip, and was sent to a local hospital for evaluation. Primary concern at that time was for her unborn child.

**Disputed Services:**

Office visits 99213 from 05/21/04 through 08/20/04.

**Decision:**

The reviewer partially agrees with the determination of the insurance carrier on this case.

**Rationale:**

It is indicated that the patient was initially injured on the job. Over a course of time, she received treatment and had undergone approximately 35 work hardening sessions, which were to be completed on or before 06/06/04. Records indicate such was completed. However, the patient continued to receive weekly office visits after the completion of the work hardening program. The records indicate the patient was evaluated on 06/18/04 by a designated doctor and was placed at maximum medical improvement and given a 5% whole person impairment rating. The dates of service in question, 05/21/04 and 05/28/04, were, in fact, reasonable, usual, customary and medically necessary for the treatment of this patient's on-the-job injury. During that period of time, the patient was assessed and received treatment necessary after the completion of the work hardening program. The office visits from 06/25/04 through 08/20/05 were not medically necessary for the treatment of this patient's on-the-job injury. The patient had been placed at maximum medical improvement and given a 5% impairment rating. She had completed 35 sessions of work hardening. Given that fact, the patient should have been released to a home therapy program. No specific schedule of once per week or once every other week was needed.