

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 G. Kris Wilson, B.S., D.C. 101 W Allen Avenue Fort Worth, Texas 76110	MDR Tracking No.: M5-05-2523-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Hartford Underwriters Insurance Box 27	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		
05-28-04	07-23-04	97110, 97112, 97116, 97530 and E0745	<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 **did** prevail on the disputed medical necessity issues. The amount of reimbursement due from the carrier for the medical necessity issues equals **\$7,125.64**.

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 06-27-05, 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 97140 dates of service 05-28-04 (1 unit), 06-01-04 (2 units), 06-02-04 (2 units), 06-03-04 (1 unit), 06-04-04 (1 unit), 06-07-04 (1 unit), 06-08-04 (2 units), 06-09-04 (1 unit), 06-10-04 (1 unit), 06-11-04 (2 units), 06-14-04 (1 unit), 06-16-04 (1 unit), 06-18-04 (2 units), 06-21-04 (1 unit) and 06-25-04 (3 units) denied with denial code "F" (reimbursement is being withheld as this procedure is considered integral to the primary procedure billed). The requestor did not provide HCFA's per Rule 133.304(k)(1)(A) so it cannot be determined what services were billed for each date of service in dispute and whether or not code 97140 is integral to the primary procedure billed. No reimbursement is recommended.

HCPCS code E1399 dates of service 05-25-04 (3 units), 06-09-04 (1 unit) and 06-18-04 (2 units) denied with denial code "F" (please submit the appropriate health care financing administration procedure coding system (HCPCS) code for the listed service). HCPCS code E1399 is a miscellaneous HCPCS code for use when no other HCPCS code is appropriate for the billing of miscellaneous DME. Per Rule 133.307(g)(3)(D) the requestor is required to discuss, demonstrate and justify that payment being sought is a fair and reasonable rate of reimbursement. The requestor did not provide sample EOBs as evidence that the fees billed are for similar treatment of injured individuals and that the fees charged are paid by other carriers. No reimbursement is recommended.

Review of CPT code 97116 dates of service 06-25-04 and 07-08-04 and code 97112 and 97530 date of service 07-08-04 revealed that neither party submitted a copy of EOBs. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing evidence of carrier receipt of the providers request for EOBs. No reimbursement is recommended.

HCPCS code E1399 dates of service 06-28-04 (1 unit), 07-06-04 (1 unit) and 07-16-04 (1 unit) denied with denial code "F" (reimbursement is being withheld as this procedure is considered integral to the primary procedure billed). The requestor did not provide HCFA's per Rule 133.304(k)(1)(A) so it cannot be determined what services were billed for each date of service in dispute and whether or not HCPCS code E1399 is integral to the primary procedure billed. No reimbursement is recommended.

HCPCS code E1399 dates of service 07-06-04 (1 unit) and 07-16-04 (1 unit) denied with denial code "D" (reimbursement for unilateral or bilateral procedures is being withheld as the maximum number of occurrences for a single date of service or maximum lifetime for the claim has been exceeded). The requestor provided documentation to support the services billed, however, per Rule 133.307(g)(3)(D) the requestor is required to discuss, demonstrate and justify that payment being sought is a fair and reasonable rate of reimbursement. The requestor did not provide sample EOBs as evidence that the fees billed are for similar treatment of injured individuals and that the fees charged are paid by other carriers. 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 \$7,125.64 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:

08-26-05

Authorized Signature

Date of Findings and Decision

Order by:

08-26-05

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

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.

Parker Healthcare Management Organization, Inc.

3719 N. Beltline Road, Irving, TX 75038

972.906.0603 972.255.9712 (fax)

Certificate # 5301

August 10, 2005

ATTN: Program Administrator

Texas Workers Compensation Commission

Medical Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100

Austin, TX 78744

Delivered by fax: 512.804.4868

Notice of Determination

MDR TRACKING NUMBER: M5-05-2523-01

RE: Independent review for ____

The independent review for the patient named above has been completed.

- Parker Healthcare Management received notification of independent review on 6.27.05.
- Faxed request for provider records made on 6.28.05.
- TWCC issued an Order for Records on 7.8.05.
- The case was assigned to a reviewer on 7.27.05.
- The reviewer rendered a determination on 8.8.05.
- The Notice of Determination was sent on 8.10.05.

The findings of the independent review are as follows:

Questions for Review

The therapy in dispute consists of the following. Therapeutic exercise (97110), Neuromuscular reeducation (97112), Gait training (97116), therapeutic activities (97530) and Neuromuscular stimulator (E0745). The services are denied for medical necessity. The dates of service are listed as 5.28.04 thru 7.23.04. This consisted of 26 visits over the two month time period.

Determination

PHMO, Inc. has performed an independent review of the proposed care to determine if the adverse determination was appropriate. After review of all medical records received from both parties involved, the PHMO, Inc. physician reviewer has determined to **overturn the denial** on the all of the denied services.

Summary of Clinical History

The patient sustained a work related job injury on ____, while employed with _____.

Clinical Rationale

The patient has a documented injury including chronic radiculopathies and significant findings on MRI studies. The therapy given lasted approximately two months or 26 visits. At the end of the therapy, the patient had improved subjectively and objectively and was dismissed from care due to documented improvement. The care did not exceed a reasonable time period of rehabilitative care for a disc injury. The patient had documented objective and subjective improvement from the care given and the therapy provided was appropriately documented. Therefore, the aforementioned care in question should be perceived as reasonable and is supported as being necessary.

Clinical Criteria, Utilization Guidelines or other material referenced

- *Occupational Medicine Practice Guidelines*, Second Edition.
- *The Medical Disability Advisor*, Presley Reed MD
- *A Doctors Guide to Record Keeping*, Utilization Management and Review, Gregg Fisher

The reviewer for this case is a doctor of chiropractic peer matched with the provider that rendered the care in dispute. The reviewer is engaged in the practice of chiropractic on a full-time basis.

The review was performed in accordance with Texas Insurance Code §21.58C and the rules of the Texas Workers Compensation Commission. In accordance with the act and the rules, the review is listed on the TWCC's list of approved providers, or has a temporary exemption. The review includes the determination and the clinical rationale to support the determination. Specific utilization review criteria or other treatment guidelines used in this review are referenced.

The reviewer signed a certification attesting that no known conflicts-of-interest exist between the reviewer and any of the providers or other parties associated with this case. The reviewer also attests that the review was performed without any bias for or against the patient, carrier, or other parties associated with this case.

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 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 Tex. Admin. Code § 148.3). This Decision is deemed received by you 5 (five) days after it was mailed and the first working day after the date this Decision was placed in the carrier representative's box (28 Tex. Admin. Code § 102.5 (d)). A request for hearing should be sent to: Chief Clerk of Proceeding/Appeals , 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 this written request for a hearing to the opposing party involved in the dispute.

I hereby verify that a copy of this Findings and Decision was faxed to TWCC, Medical Dispute Resolution department applicable to Commission Rule 102.5 this 10th day of August 2005. The TWCC Medical Dispute Resolution department will forward the determination to all parties involved in the case including the requestor, respondent and the injured worker. Per Commission Rule 102.5(d), the date received is deemed to be 5 (five) days from the date mailed and the first working day after the date this Decision was placed in the carrier representative's box.

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.

CC: Requestor
Respondent
Patient