

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 Summit Rehabilitation Centers 2500 West Freeway # 200 Fort Worth, Texas 76102	MDR Tracking No.: M5-05-2558-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address AMCOMP Assurance Company Box 34	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		
05-14-04	05-14-04	97750-FC	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
05-14-04	10-19-04	99213 and 99372	<input type="checkbox"/> Yes <input checked="" 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 not** prevail on the **majority** of disputed medical necessity issues. The amount due from the carrier for the medical necessity issues equals **\$444.60**.

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 06-22-05, 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 99213 dates of service 09-01-04, 09-10-04, 09-15-04 and 10-28-04 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for EOBs. Reimbursement is recommended in the amount of **\$272.96 (\$68.24 X 4 DOS)**.

CPT codes 97545-WC and 97546-WC dates of service 05-10-04 and 05-11-04 were paid by the carrier. Payment was confirmed with the requestor, therefore, these dates of service are no longer in dispute.

CPT code 99213 date of service 08-11-04 denied with denial code "D" (duplicate bill). Since neither party submitted an

original EOB the review will be per Rule 134.202. Reimbursement is recommended in the amount of **\$68.24**.

CPT code 99372 date of service 08-11-04 denied with denial code "D" (duplicate bill). CPT code 99372 is a bundled service. No reimbursement is recommended.

Review of CPT code 99080-73 date of service 09-01-04 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. Reimbursement is recommended in the amount of **\$15.00**.

CPT code 99080-73 date of service 10-01-04 denied with denial code "V" (unnecessary medical treatment with 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 **\$15.00**. A Compliance and Practices referral will be made as the carrier is in violation of Rule 129.5.

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 reimbursement totaling \$815.80 for services involved in this dispute and is **not** entitled to a refund of the paid IRO fee. The Division hereby **ORDERS** the insurance carrier to remit the appropriate amount for the services in dispute 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 and Order by:

Authorized Signature

07-20-05

Date of Decision and 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:	M5-05-2558-01
Name of Patient:	_____
Name of URA/Payer:	Summit Rehabilitation Centers
Name of Provider: (ER, Hospital, or Other Facility)	Summit Rehabilitation Centers
Name of Physician: (Treating or Requesting)	Marivel C. Subia, DC

July 13, 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

Documents Reviewed Included the Following:

1. Correspondence, examination and S.O.A.P. notes from the provider.
2. Carrier Review
3. FCE
4. Report of Michael Taba, M.D.
5. Report of Kevin Nguyen, D.P.M.
6. Impairment rating of Chris Bowers, D.P.M.

Patient underwent physical medicine treatments, surgery and FCE after he sustained foot fractures at work on ____ when a bull dozer ran over his left foot.

REQUESTED SERVICE(S)

Functional Capacity Evaluation (97750-FC), office visits (99213) and phone call (99372) from 05/14/04 through 10/19/04.

DECISION

The 05/14/04 FCE is approved.

All office visits (99213) and the phone call (99372) are denied.

RATIONALE/BASIS FOR DECISION

After completing a 6-week work hardening program, it would be reasonable and medically necessary to determine the claimant's work status by performing a functional capacity evaluation.

Most computerized documentation, regardless of the software used, fails to provide individualized information necessary for reimbursement. The Center for Medicare and Medicaid Services (CMS) has stated, "Documentation should detail the specific elements of the chiropractic service for this particular patient on this day of service. It

should be clear from the documentation why the service was necessary that day. Services supported by repetitive entries lacking encounter specific information will be denied."

In this case, there is insufficient documentation to support the medical necessity for any of the office visits (99213) or the phone call (99372) since the computer-generated progress notes were essentially identical for each date of service. In fact, the treatment records failed to document that the examinations were actually performed.

Moreover, based on CPT ¹, there is no support for the medical necessity for that repeated high level of E/M service (99213) for a foot injury.

¹ *CPT 2004: Physician's Current Procedural Terminology, Fourth Edition, Revised.* (American Medical Association, Chicago, IL 1999),