

# 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  Northwest Chiropractic 2351 W. Northwest Hwy #1130 Dallas, Teas75220	MDR Tracking No.: M5-05-2580-01
	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.:

### PART II: SUMMARY OF DISPUTE AND FINDINGS - Denied for Medical Necessity

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
1-17-05	2-16-05	CPT codes 97032, 97035, 1 unit of 97140, 97110	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
1-17-05	2-16-05	More than 1 unit of 97140	<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 **prevailed** on the majority of the disputed medical necessity issues.

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 8-15-05 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.

The carrier denied CPT code 97535 on 1-27-05 and 2-10-05 with "434 - the value of the procedure is included in the value of the mutual exclusive procedure." According to the 2002 MFG this procedure is considered by Medicare to be a component procedure of CPT code 97530. Recommend no reimbursement.

The carrier denied CPT code 97112 on 1-27-05, 2-2-05, 2-10-05 with "434 - the value of the procedure is included in the value of the mutual exclusive procedure." According to the 2002 MFG this procedure is considered by Medicare to be a component procedure of CPT code 97150. Recommend no reimbursement.

The carrier denied CPT code 97110 on 1-27-05, 1-28-05, 2-2-05, 2-4-05, 2-7-05, 2-10-05 and 2-16-05 with "434 - the value of the procedure is included in the value of the mutual exclusive procedure." 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. Recommend no reimbursement.

The carrier denied CPT code 97530 on 2-10-05 with "434 - the value of the procedure is included in the value of the mutual exclusive procedure." According to the 2002 MFG this procedure is considered by Medicare to be a component procedure of CPT code 97150. Recommend no reimbursement.

The carrier denied CPT code 97140 on 1-27-05, 1-28-05, 2-2-05, 2-4-05, 2-7-05, 2-10-05 and 2-16-05 with "434 - the value of the procedure is included in the value of the mutual exclusive procedure." According to the 2002 MFG this procedure is considered by Medicare to be a component procedure of CPT code 97150. Recommend no reimbursement.

#### **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 \$460.00. The Division hereby **ORDERS** the insurance carrier to remit the amount of \$714.80, plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

8-31-05

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

## NOTICE OF INDEPENDENT REVIEW DECISION

August 9, 2005

Amended Letter 8/29/05

Program Administrator  
Medical Review Division  
Texas Workers Compensation Commission  
7551 Metro Center Drive, Suite 100, MS 48  
Austin, TX 78744-1609

RE: Injured Worker:  
MDR Tracking # : M5-05-2580-01  
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. TMF's health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

### Clinical History

This 23 year-old male injured his back on \_\_\_\_ when metal pipes pinned him around his chest and back. He has been treated with medications and therapy.

### Requested Service(s)

Electrical stimulation, ultrasound, manual therapy technique, therapeutic exercises for dates of service 01/17/05 through 02/16/05

### **Decision**

It is determined there is medical necessity for the electrical stimulation, ultrasound, and therapeutic exercises for dates of service 01/17/05 through 02/16/05. It is also determined there is medical necessity for manual therapy technique; however, only one unit per visit was medically necessary to treat this patient's medical condition for the dates in question.

### Rationale/Basis for Decision

Medical record documentation indicates this patient was injured in a work related event. According to the Guidelines for Chiropractic Quality Assurance and Practice Parameters<sup>1</sup>, there is sufficient documentation to justify the 8 weeks of post-injury therapy this patient received for his injury. Therefore, the electrical stimulation, ultrasound, and therapeutic exercises for dates of service 01/17/05 through 02/16/05 were medically necessary to treat this patient's medical condition. Additionally, these guidelines allow for manual therapy techniques as well for this type of injury; however, only one unit of manual therapy technique per visit is medically necessary to treat this patient medical condition for dates of service 01/17/05 through 02/16/05.

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<sup>1</sup> Haldeman, S; Chapman-Smith, D; Petersen, D Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen Publishers, Inc.

Sincerely,

Gordon B. Strom, Jr., MD  
Director of Medical Assessment

GBS:dm

## Information Submitted to TMF for TWCC Review

**Patient Name:** \_\_\_\_\_

**TWCC ID #:** M5-05-2580-01

**Information Submitted by Requestor:**

- Progress notes
- Diagnostic Tests

**Information Submitted by Respondent:**

- None