

# 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 Carl M. Naehritz, III, D.C. 2900 Highway 121, Suite 120 Bedford, Texas 76121	MDR Tracking No.: M5-05-2582-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address American Home Assurance Company Box 19	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		
07-31-03	01-21-04	E1399-RR, 97112, 97140 and E0215	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input 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.

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. The DME, neuromuscular re-education, supplies and materials and manual therapy services, rendered on 07-31-03 through 01-21-04 were found to be medically necessary. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division. The reimbursement amount due from the carrier for the medical necessity issues equals **\$1,332.77**.

On 07-02-2004, 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 99070 date of service 05-16-03 denied with denial code "R" (charge unrelated to compensable injury). The carrier has not filed a TWCC-21. Per Rule 133.307(g)(3)(A-F) the requestor submitted documentation supporting delivery of services. Reimbursement is recommended in the amount of **\$30.00**.

CPT code 95851 (4 units) date of service 08-19-03 denied with denial code "F" (reimbursement according to Texas Medical Fee Guidelines). The carrier made a payment of \$133.60. Reimbursement per Rule 134.202(c)(1) is \$99.52 (\$19.90 X 125% = \$24.88 X 4 units). No additional reimbursement is recommended.

CPT code 97112-59 date of service 10-10-03 revealed that the respondent submitted an EOB, however, no denial code was given on the EOB. Per Rule 133.304(c) the “explanation of benefits shall include the correct payment exception codes required by the Commission’s instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier’s action(s)”. Reimbursement is \$35.66 per Rule 134.202(c)(1), however, the requestor billed \$35.26 therefore reimbursement is recommended in the amount of **\$35.26**.

CPT code 99213-59 date of service 10-22-03 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 per Rule 133.307(g)(3)(A-F) submitted documentation to support delivery of services. No payment has been made by the carrier. Reimbursement is \$65.18 per Rule 134.202(c)(1), however, the requestor billed \$62.81 therefore reimbursement is recommended in the amount of **\$62.81**.

CPT code 97750-FC (2 hours billed or 8 units) date of service 10-28-03 denied with denial code “F” (processed according to the Texas Fee Guidelines). The carrier has made a payment of \$70.52. Reimbursement per Rule 134.202(c)(1) is \$285.28. The requestor billed \$200.00. Additional reimbursement is recommended in the amount of **\$129.48**.

Review of CPT codes 99358-22 date of service 12-19-03, code 97750-FC date of service 12-31-03 and HCPCS code E0215 date of service 12-31-03 revealed that neither party submitted copies 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.

CPT code 99372 date of service 12-19-03 denied with denial code “S” (reimbursement is based upon documentation and/or additional information provided). The carrier has made a payment of \$48.20. This is a bundled fee per the Medicare guidelines and is not paid separately. No additional reimbursement is recommended.

CPT code 97140-59 date of service 01-02-04 denied with denial code “F” (processed according to the Texas Fee Guidelines). The carrier has not made a payment. Reimbursement per Rule 134.202(c)(1) is recommended in the amount of **\$32.90 (\$26.32 X 125%)**.

HCPCS code E0900 (DME) date of service 01-02-04 denied with denial code “F” (processed according to the Texas Fee Guidelines). The carrier has made a payment of \$147.43. The requestor did not bill the service with a modifier, therefore, a determination cannot be made as to the amount of reimbursement due. The requestor also did not provide relevant information (i.e. redacted EOBs-with same or similar services-showing amount billed is fair and reasonable). Therefore, no additional reimbursement is recommended.

CPT code 97546-WH dates of service 01-12-04 (4 units) and 01-16-04 (2 units) denied with denial code “F” ” (processed according to the Texas Fee Guidelines). The carrier has made a payment of \$307.20. Additional reimbursement is recommended in the amount of **\$76.80**.

CPT code 97545-WH date of service 01-16-04 (2 units) denied with denial code “F” ” (processed according to the Texas Fee Guidelines). The carrier has made a payment of \$102.40. Additional reimbursement is recommended in the amount of **\$25.60**.

CPT code 99358-22 date of service 01-17-04 denied with denial code “N” (additional documentation required to substantiate procedure and/or charged amount). The requestor did not submit documentation for review. No reimbursement recommended.

CPT code 99372 date of service 01-19-04 denied with denial code “N” (additional documentation required to substantiate procedure and/or charged amount). This is a bundled fee per the Medicare guidelines and is not paid separately. No reimbursement is recommended.

The total reimbursement due from the carrier for the fee issues equals **\$392.85**.

**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 \$1,725.62, plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

07-08-05

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**

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

**REVISED 6/30/05**

TWCC Case Number:	
MDR Tracking Number:	M5-05-2582-01
Name of Patient:	
Name of URA/Payer:	Carl M. Naehritz III, DC
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Carl M. Naehritz III, DC

July 27, 2004

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

### CLINICAL HISTORY

Patient underwent physical medicine treatments and lumbar injections after sustaining an on-the-job injury on \_\_\_\_.

### REQUESTED SERVICE(S)

Durable medical equipment, 99070 supplies and materials, neuromuscular reeducation, manual therapy on 07/31/03, 08/19/03, 10/20/03, 11/03/03 and 01/21/04.

### DECISION

Approved.

### RATIONALE/BASIS FOR DECISION

The submitted medical records, including the doctor's daily treatment notes, more than adequately document the medical necessity for the treatment rendered and the durable medical equipment supplied on the dates in question. Specifically, the medical records document that the treatment met the statutory standard since it relieved the effects of the compensable injury.