

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 Network of Physicians Management, Inc. 943 North Expressway # 15, PMB 9100 Brownsville, Texas 78520	MDR Tracking No.: M5-05-2669-01
	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

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
07-22-04	08-16-04	97035	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
07-30-04	07-30-04	97110 (2 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
08-05-04	08-05-04	97110 (2 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
07-22-04	12-15-04	97110 (with the exception listed above), 99212, G0283 and 97035 (with the exception listed above)	<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 **\$113.68 (total does not include 97110 for dates of service 07-30-04 and 08-05-04 as the IRO found 2 units each date of service to be necessary and the carrier had previously reimbursed 2 units).**

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 07-12-2005, 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 99080-73 date of service 06-07-04 denied with denial codes "F/TD/N" (Fee guideline MAR reduction, the work status report was not properly completed or was submitted in excess of the filing requirements/not appropriately documented). The carrier has made no payment. The requestor submitted documentation that supports the service billed. Per the 2002 Medical Fee Guideline reimbursement is recommended in the amount of **\$15.00**.

CPT code 99455-VR date of service 06-15-04 denied with denial code "U/N" (unnecessary medical without peer review/not appropriately documented). Per Rule 134.202(E)(6)(B)(iii) the carrier denied with an inappropriate denial code. This is a required report which is not subject to an IRO review. The carrier will be referred to Compliance & Practices due to a violation of Rule 134.202(E)(6)(B)(iii). The requestor did not submit documentation for review. No reimbursement is recommended.

CPT code 99080-73 dates of service 07-13-04, 08-11-04, 08-27-04, 09-10-04, 09-27-04 and 10-11-04 denied with denial codes 248/TD/891” (TWCC 73 not properly completed or submitted in excess of the filing requirements/the insurance company is reducing or denying payment after reconsidering a bill). The requestor submitted copies of the required reports for review which support the services billed. Reimbursement in the amount of **\$90.00** is recommended per Rule 133.106(f)(1).

CPT code 99214 date of service 07-21-04 denied with denial code “N/F” (not appropriately documented/Fee guideline MAR reduction). The carrier has not made a payment. The requestor submitted documentation for review which supports the service billed. Reimbursement per the 2002 Medical Fee Guideline is recommended in the amount of \$96.91, however, the requestor billed \$92.30, therefore **\$92.30** is recommended.

CPT code 99212 date of service 08-23-04, 08-25-04, 08-27-04 and 09-07-04 denied with denial code “57” (payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, length of service, dosage or this day’s supply). The requestor submitted documentation that supports the services billed. Reimbursement per the 2002 Medical Fee Guideline is recommended in the amount of \$44.16, however, the requestor billed \$41.91 for each date of service in dispute. Reimbursement is recommended in the amount of **\$167.64**.

PART IV: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to a refund of the paid IRO. The Division hereby **ORDERS** the insurance carrier to remit the appropriate amount for the services in dispute totaling \$478.62 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

08-11-05

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

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.

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:	M5-05-2669-01
Name of Patient:	
Name of URA/Payer:	Network of Physicians Mgmt.
Name of Provider: (ER, Hospital, or Other Facility)	Network of Physicians Mgmt.
Name of Physician: (Treating or Requesting)	Mark Crawford, DC

July 28, 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 treatment records from the provider
2. Correspondence from the carrier
3. Operative Reports
4. Designated Doctor Examination and Report
5. Diagnostic imaging reports
6. EOBs
7. FCE

Patient underwent FCE, diagnostic imaging, physical medicine treatments and 3 surgeries after injuring his right knee at work on ___ when he pulled heavy material on a conveyer belt with a hook.

REQUESTED SERVICE(S)

Therapeutic exercises (97110), ultrasound (97035), electrical stimulation unattended (G0283), office visits (99212), and manual therapy technique (97140) not marked as "Fee" denials from 07/22/04 through 12/15/04.

DECISION

All ultrasound treatments (97035) from 07/22/04 through 08/16/04 are approved. A maximum of two units of therapeutic exercises on DOS 07/30/04 and DOS 08/05/04 are also approved.

All other disputed treatments and procedures are denied.

RATIONALE/BASIS FOR DECISION

Physical medicine is an accepted part of a rehabilitation program following surgery. However, for medical necessity to be established, there must be an expectation of recovery or improvement within a reasonable and generally predictable time period. In addition, the frequency, type and duration of services must be reasonable and consistent with the standards of the health care community. The *Guidelines for Chiropractic Quality Assurance and Practice Parameters*

1 Chapter 8 under "Failure to Meet Treatment/Care Objectives" states, "After a maximum of two trial therapy series of manual procedures lasting up to two weeks each (four weeks total) without significant documented improvement, manual procedures may no longer be appropriate and alternative care should be considered." Therefore, certain active and passive treatments for the 4-week period ending 08/16/04 were medically indicated. However, there was no support in the records to continue care beyond that date.

Physical medicine treatment requires ongoing assessment of a patient's response to prior treatment and modification of treatment activities to effect additional gains in function. Patients should be formally assessed and re-assessed periodically to see if the patient is moving in a positive direction in order for the treatment to continue.

Moreover, evidence of objective functional improvement is essential to establish reasonableness and medical necessity of treatment. In this case, this type of necessary documentation was wholly lacking.

Based on CPT 2, there is also no support for the medical necessity for the office visits (99212) on most every visit during an established treatment plan.

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

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