



Texas Department of Insurance, Division of Workers' Compensation
 7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION
Retrospective Medical Necessity and Fee Dispute

PART I: GENERAL INFORMATION

Type of Requestor: Health Care Provider Injured Employee Insurance Carrier

Requestor's Name and Address: Killeen Rehab Group 5445 La Sierra Drive, Suite 204 Dallas, Texas 75231	MDR Tracking No.: M5-05-2684-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Box 45	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

SORM has reduced the payments for this patients claims. They did not pay the MAR.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The office will maintain denial of the charges in dispute and will await additional documentation for formal response of fee issues.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
12-08-04	97032 (1 unit)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$18.73
01-05-05	97112 (1 unit)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$35.21
01-05-05	97530 (3 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$105.45
01-13-05, 01-28-05 and 01-31-05	97112 and 97530	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
01-28-05 and 02-02-05	97124 and 97110	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
01-31-05 and 02-02-05	971124	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
01-31-05	99213	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00

PART V: 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 Division Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), Medical Dispute Resolution 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 **\$159.39**.

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 Medical Dispute Resolution.

On 07-14-2005, 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 97032 dates of service 11-15-04, 11-24-04, 12-01-04 and 12-02-04 denied with denial code – F – (Fee Guideline MAR reduction). No payment has been made by the carrier. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$74.92** ($\$14.98 \times 125\% = \$18.73 \times 4 \text{ DOS}$).

CPT code 97124 dates of service 12-20-04, 12-23-04, 12-30-04 and 01-07-05 denied with denial code – G – (unbundling). Per the 2002 Medical Fee Guideline code 97124 is not global to other services billed on the dates of service in dispute. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$105.47** (**\$78.84 for DOS 2004 and \$26.63 for DOS 2005**).

CPT code 97112 dates of service 12-20-04, 12-23-04, 12-30-04 and 01-07-05 denied with denial code – G – (unbundling). Per the 2002 Medical Fee Guideline code 97112 is not global to other services billed on the dates of service in dispute. Reimbursement is recommended per Rule 134.202(c)(1) in the amount **\$138.11** (**\$102.90 for DOS 2004 and \$35.21 for DOS 2005**).

Review of CPT code 97032 date of service 11-12-04 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing evidence of carrier receipt of the providers request for an EOB. No reimbursement recommended.

CPT code 97124 dates of service 11-22-04 and 01-03-05 denied with denial codes –F- and –R38- (Fee Guideline MAR reduction and included in another billed procedure). The carrier has made no payment. Per the 2002 Medical Fee Guideline code 97124 is not global to other services billed on the dates of service in dispute. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$52.91** (**\$26.28 2004 DOS and \$26.63 2005 DOS**).

CPT code 99212 date of service 12-27-04 denied with denial code –G- unbundling). Per the 2002 Medical Fee Guideline code 99212 is not global to other services billed on the date of service in dispute. Reimbursement is recommended per Rule 134.202(c)(1) in the amount **\$44.16**.

CPT code 97112 date of service 01-03-05 denied with denial codes –F- and –R38- (Fee Guideline MAR reduction and included in another billed procedure). The carrier has made no payment. Per the 2002 Medical Fee Guideline code 97112 is not global to other services billed on the date of service in dispute. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$35.21**.

CPT code 97032 date of service 01-07-05 denied with denial code –G- (unbundling). Per the 2002 Medical Fee Guideline code 97032 is not global to other services billed on the date of service in dispute. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$19.00**.

CPT code 97530 (3 units) date of service 01-07-05 denied with denial codes –F- and –N- (Fee Guideline MAR reduction and not appropriately documented). The carrier has made no payment. The requestor per Rule 133.307(g)(3)(A-F) submitted documentation to support the service in dispute. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$105.45 (\$35.15 X 3 units)**.

CPT code 97750 (6 units) date of service 01-24-04 denied with ANSI denial code –W1- (Workers' Compensation Fee Schedule Adjustment). The carrier has made a payment of \$102.90. Additional reimbursement per Rule 134.202(c)(1) is recommended in the amount of **\$102.90 (\$205.80 minus carrier payment)**.

CPT code 97110 (4 units) date of service 01-31-05 denied with ANSI denial code –W1- (Workers' Compensation Fee Schedule Adjustment). The carrier has made a payment of \$100.68. The requestor submitted documentation to support the service in dispute. Additional reimbursement per Rule 134.202(c)(1) is recommended in the amount of **\$33.56 (MAR of \$134.24 minus carrier payment)**.

CPT code 90806 date of service 01-14-05 denied with denial code –G- (unbundling). Per the 2002 Medical Fee Guideline CPT code 90806 is global to CPT code 90880 billed on the same date of service. No reimbursement is recommended.

CPT code 90880 date of service 01-14-05 denied with denial code –F- (Fee Guideline MAR reduction). The carrier has not made a payment. Reimbursement per Rule 134.202(c)(1) is \$149.99 (\$119.99 X 125%), however, the requestor billed \$90.00 therefore **\$90.00** is the recommended reimbursement.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, Rule 134.202(c)(1), 2002 Medical Fee Guideline, Rule 133.307(e)(2)(B), Rule 133.307(g)(3)(A-F) and ANSI claim adjustment reason code text.

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the requestor is entitled to reimbursement in the amount of \$961.08.

In addition, the Division finds that the requestor is not entitled to a refund of the IRO fee. The Division hereby **ORDERS** the insurance carrier to remit payment plus all accrued interest due at the time of payment to the Requestor within 30 days of receipt of this Order.

Findings and Decision and Order by:

Authorized Signature

09-21-05

Date of Order

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and 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. The Division is not considered a party to the appeal.

Si prefiere hablar con una persona en 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 16, 2005

Amended: September 20, 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: M5-05-2684-01
RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 7.12.05.
- Faxed request for provider records made on 7.12.05.
- The case was assigned to a reviewer on 8.1.05.
- The reviewer rendered a determination on 8.12.05.
- The Notice of Determination was sent on 8.16.05.
- TWCC requested an amendment of the determination on 9.20.05.

The findings of the independent review are as follows:

Questions for Review

The medical necessity of the following services are in question: therapeutic exercise (97110), Electrical stimulation (97032), Neuromuscular reeducation (97112), therapeutic activities (97530) and massage therapy (97124). The dates of service that are in dispute are 12-8-04, 1-5-05, 1-13-05, 1-28-05, 1-31-05 and 2-2-05. The date of injury is listed as ____.

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 dates of 12-8-04-code 97032 and the date of 1-5-05 –code 97112, 97530.

PHMO, Inc. physician reviewer has determined to **uphold the denial** of all services not specifically approved hereinbefore.

Summary of Clinical History

The patient was injured while working for the _____ On the date of injury, she was walking on a wet floor that had been painted with high gloss paint. As a result she was unable to recognize any water on the floor and as a result she fell and hit her elbow. Later reports demonstrate that her left knee is also injured and has involvement. On a report date 11-16-04 the patient was given diagnoses of lateral meniscus tear, left lateral collateral ligament strain and left cruciate strain. An MRI later in care demonstrates a medial meniscus, posterior horn pathology with MCL sprain and suprapatellar joint effusion and some probable bone contusions. Since then she has received various forms of care and therapy.

The patient did initially visit Scott and White Medical Center and was diagnosed with contusion of the right elbow. No mention was made of the left knee at that time. It was listed that the patient is functioning with restrictions at that time and no restrictions were listed. She was seen again at the same facility on the date of 6-15-04. There was documentation again that the patient was concerned about the continuation of elbow pain. On 6-28-04 the patient was seen again at the same facility and documented findings from an MRI to the elbow, again, no mention was made of the left knee. Again, two months after the date of injury there is no mention of left knee pain. The rendering practitioner told the patient that a bone contusion can cause pain up to 6 months. The designated doctor on the date of 10-26-04 found the left knee injury and brought attention to it. He also states that no therapy was initiated in the form of rehabilitative care. The designated doctor states the elbow is better at this time, but the knee, which was never initially reported, is now the chief complaint.

After this, the patient was examined by Christopher Blair, DC. After this initial visit the patient started the care listed as disputed.

Clinical Rationale

The designated doctor in October, 2004 stated that he determined the patient had never received care before in the form of rehabilitation. The patient then was examined by Dr. Blair and an examination was performed. The initial examination clearly documented range of motion loss, strength loss, pain and injury. This laid the foundation for the need for rehabilitative care. Care was then initiated. During the time period of treatment in question there is no clear objective documentation that reveals the patient improved. There was no follow up documented outcome assessment or findings similar to that listed in the initial report of 11-12-04 to demonstrate if there was any improvement from the administered care. As a result I cannot see that care beyond a reasonable trial period of care for 4 weeks would be reasonable. There was no clear benefit from the care during two months of treatment. Having said this, a continuation of the same form of conservative treatment is not likely to ever have a great impact on the patient's condition, at least pre-surgically. Post surgically the need for rehabilitative care is a different scenario.

The patient was listed as surgical as revealed in a report by Dr. Benson on 12-29-04 for the knee. Continuing therapy of a conservative nature for a knee that is clearly listed as surgical and is not improving from the listed conservative treatment is not reasonable. The final note by Dr. Benson on 1-17-05 states her surgery was to be done on 2-4-05. He states the only thing that has helped her is pain medication, he never references ongoing conservative treatment or continued conservative treatment as a form of therapy that really ever made a difference in the patient's condition or symptoms. Pre-surgical rehabilitation is at times necessary, but there still has to be a documented benefit from that form of therapy to support its ongoing necessity for extenuated time periods. There was never any clear objective benefits listed to do this.

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 16th day of August, 2005. The determination was amended and resubmitted to TWCC on this 20th day of September, 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