

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 Allied Multicare Centers 415 Lake Air Drive Waco, Texas 76710	MDR Tracking No.: M5-05-2710-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address ARCFMI %Flahive, Ogden and Latson, Box 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS – MEDICAL NECESSITY ISSUES

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
7-16-04	9-1-04	CPT codes 97124, 98943, 97110, 97112, 97530, 99212	<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 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.

On 7-18-05 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 EOB for CPT code 99213 on 8-5-04 reflects that the carrier has reimbursed the requestor for this service. This was not verified with the Requestor. Recommend reimbursement of \$61.98.

CPT code 99213 on 7-16-04 was CPT code was denied with denial code "N – not appropriately documented." The requestor did not provide documentation to support delivery of service per Rule 133.307(g)(3)(A-F) or medical notes to support the criteria for that service. Reimbursement is not recommended.

CPT code 97110 on 7-16-04 was CPT code was denied with denial code "N – not appropriately documented." The requestor did not provide documentation to support delivery of service per Rule 133.307(g)(3)(A-F) or medical notes to support the criteria for that service. Reimbursement is not recommended.

CPT code 97112 on 7-16-04 was CPT code was denied with denial code "N – not appropriately documented." The requestor did not provide documentation to support delivery of service per Rule 133.307(g)(3)(A-F) or medical notes to support the criteria for that service. Reimbursement is not recommended.

CPT code 97530 on 7-16-04 was CPT code was denied with denial code "N – not appropriately documented." The requestor did not provide documentation to support delivery of service per Rule 133.307(g)(3)(A-F) or medical notes to support the criteria for that service. Reimbursement is not recommended.

CPT code 97124 on 7-16-04 was CPT code was denied with denial code "N – not appropriately documented." The requestor did not provide documentation to support delivery of service per Rule 133.307(g)(3)(A-F) or medical notes to support the criteria for that service. Reimbursement is not recommended.

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 fee. The Division hereby **ORDERS** the insurance carrier to remit the appropriate amount for the services in dispute totaling \$61.98, plus all accrued interest due at the time of payment, to the Requestor within 20-days of receipt of this Order.

Findings and Decision by:

Donna Auby

8-15-05

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.

August 9, 2005

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-05-2710-01
TWCC#: _____
Injured Employee: _____
DOI: _____
SS#: _____
IRO Certificate No.: IRO 5055

Dear ____:

IRI has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc. and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is licensed in chiropractic, and is currently on the TWCC Approved Doctor List.

Sincerely,

Gilbert Prud'homme
General Counsel

GP:thh

REVIEWER'S REPORT
M5-05-2710-01

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor:

Office notes 05/27/04 – 09/09/04

Physical therapy notes 05/27/04 – 09/23/04

Electrodiagnostic test 06/22/04

Radiology reports ____ – 06/23/03

Information provided by Respondent:

Correspondence

Designated doctor reviews

Clinical History:

This female patient underwent physical medicine treatments, diagnostic imaging and electrodiagnostic testing after sustaining injury at work on ____.

Disputed Services:

Massage therapy, chiropractic manipulation, therapeutic exercises, neuromuscular re-education, therapeutic activities and office visits during the period of 07/16/04 thru 09/01/04

Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were not medically necessary in this case.

Rationale:

In general, 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 the treatment in question since the computer-generated daily progress notes were essentially identical for each date of service.

The disputed treatment in this case also failed to fulfill statutory requirements ¹ for medical necessity since the patient obtained no relief, promotion of recovery was not accomplished and there was no enhancement of the employee's ability to return to or retain employment. Specifically, the patient's pain was rated at "moderate," "unchanged" and/or the "same as last visit" on every single date of service.

Moreover, the claimant's ankle ranges of motion actually decreased from the examination performed on 07/13/04 (prior to the disputed treatment) to the examination performed on 09/09/04 (at the termination of the disputed treatment). While it appears that the 07/13/04 measurements were in error, they are the only figures available and the provider certified that the measurements were obtained "...with dual inclinometry and all testing was valid."

¹ Texas Labor Code 408.021