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 Pain & Recovery Clinic C/o Bose Consulting LLC P O BOX 550496 Houston, Texas 77255	MDR Tracking No.: M5-05-2756-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Employers Insurance Company of Wausau Box 28	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		
12-20-04	01-31-05	99212-25, 99214-25	☐ Yes ☒ No
12-22-04	01-31-05	97018, 97035, 97140, 97110, 97032 and E1399	☒ Yes ☐ 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 disputed medical necessity issues. The total amount due from the carrier for the medical necessity issues equals **$1,196.97** (this total does not include HCPCS code E1399 as this is a DOP code and per Rule 133.307(g)(3)(D), the requestor is required to discuss, demonstrate and justify that the payment being sought is a fair and reasonable rate of reimbursement. The requestor has not provided sample EOBs as evidence that the fees billed are for similar treatment of injured individuals and that reflect the fee charges to and paid by other carriers, therefore no reimbursement for this code is included in the total amount calculated due by the carrier).

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 07-22-05, 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.

CPT code 97018-59 date of service 12-20-04 denied with denial code "G/U687" (this procedure is mutually exclusive to another on this date of service). Per the 2002 Medical Fee Guideline code 97018 is a component of code 97140 billed on the same date of service. Separate payment for the service billed may be considered justifiable if a modifier is used

appropriately. The 59 modifier is an appropriate modifier. Reimbursement is recommended in the amount of **$8.64.**

CPT code 97124-59 date of service 12-20-04 denied with denial code "G/U687" (this procedure is mutually exclusive to another on this date of service). Per the 2002 Medical Fee Guideline code 97124 is a component of code 97140 billed on the same date of service. There are no circumstances in which a modifier would be appropriate. No reimbursement is recommended.

CPT code 97035-59 date of service 12-20-04 denied with denial code "F/Z560" (the charge for this procedure exceeds the fee schedule or usual and customary allowance). The carrier has made no payment. Reimbursement is recommended in the amount of **$15.78** per Rule 134.202(c)(1).

CPT code 97140-59 date of service 12-20-04 denied with denial code "F/Z560" (the charge for this procedure exceeds the fee schedule or usual and customary allowance). The carrier has made no payment. Reimbursement is recommended in the amount of **$33.91** per Rule 134.202(c)(1).

CPT code 97110-59 date of service 12-20-04 denied with denial code "F/Z560" (the charge for this procedure exceeds the fee schedule or usual and customary allowance). The carrier has made no payment. 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". The requestor submitted documentation, however, the documentation did not clarify one-on-one therapy. 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 of all of the Commission requirements for proper documentation. No reimbursement is recommended.

Review of CPT code 99080-73 date of service 12-29-04, codes 99212, 97018, 97035, 97110, 97032 dates of service 01-03-05 and 01-05-05 and HCPCS code E1399 date of service 01-03-05 revealed that neither party submitted copies of EOBs. The requestor per Rule 133.307(e)(2)(B) provided convincing evidence of carrier receipt of the providers request for EOBs. Reimbursment is recommended per the 2002 Medical Fee Guideline as below:

99080-73 - **$15.00**
99212 - **$98.82** ($49.41 X 2 DOS)
97018 - **$17.28** ($8.64 X 2DOS)
97035 - **$31.06** ($15.53 X 2 DOS)
97110 - No reimbursement recommended. (see above description-the requestor submitted documents, however, the documentation submitted did not clarify one-on-one therapy.
97032 - **$40.68** ($20.34 X 2 DOS)
E1399 - No reimbursement. This is a DOP code and per Rule 133.307(g)(3)(D), the requestor is required to discuss, demonstrate and justify that the payment being sought is a fair and reasonable rate of reimbursement. The requestor did not provide sample EOBs as evidence that the fees billed are for similar treatment of injured individuals and that reflect the fee charges to and paid by other carriers.

CPT code 99080-73 date of service 01-31-05 denied with denial code "V" (unnecessary medical treatment with peer review). The TWCC-73 is a required report per Rule 129.5 and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. Reimbursement is recommended in the amount of **$15.00.**

PART IV: COMMISSION DECISION

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 this amount and the appropriate amount for the services in dispute totaling $1,473.14 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:

		08-31-05
Authorized Signature		Date of Decision

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:	M5-05-2756-01
Name of Patient:	___
Name of URA/Payer:	Pain & Recovery Clinic c/o Bose Consult.
Name of Provider: (ER, Hospital, or Other Facility)	Pain & Recovery Clinic
Name of Physician: (Treating or Requesting)	William Hicks, DC

August 18, 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. Report from Bose Consulting, LLC
3. Electrodiagnostic Report
4. Reports of Jacob Varon, M.D.
5. Report of James B. Stafford, M.D.
6. Report of Tuan M. Hoang, D.C.
7. Reports of RME Emmie, Ko, M.D.
8. First page of the carrier review
9. Carrier correspondence
10. EOBs

The claimant underwent examinations and physical medicine treatments after a metal frame corner fell from a table and injured his hand on ___.

REQUESTED SERVICE(S)
Office visits – 99212-25/99214-25, paraffin bath – 97018-59, ultrasound 97035-59, manual therapy technique – 97140-59, therapeutic exercises – 97110-59, electrical stimulation (manual) – 97032-59, DME E1399 not indicated as "fee" issues from 12/20/04 through 01/31/05.

DECISION
All office visits are denied.

All other treatments and procedures are approved.

RATIONALE/BASIS FOR DECISION
The provider's Bose Consulting, LLC report is completely without foundation. It contains verbatim "boilerplate" language that has been submitted in other MDRs. Therefore, it is not specific to

this case and is without any standing whatsoever.

Based on CPT [1], there is no support for the medical necessity for the high level E/M services (99212-25/99214-25) on each and every visit during an established treatment plan.

Expectation of improvement in a patient's condition should be established based on success of treatment. Continued treatment is expected to improve the patient's condition and initiate restoration of function. If treatment does not produce the expected positive results, it is not reasonable to continue that course of treatment. With documentation of improvement in the patient's condition and restoration of function, continued treatment may be reasonable and necessary to effect additional gains. In this case, there is adequate documentation that the treatment could have been reasonably expected to result in objective and functional improvement in this patient's condition and thus would have fulfilled statutory requirements[2] for medical necessity by relieving pain, promoting recovery or enhancing the employee's ability to return to or retain employment.

This position is supported by the RME performed by Emmie Ko, M.D. on 02/16/05. In the report, Dr. Ko opined that the claimant was still not at MMI and stated, "Yes, the length and frequency of treatment is reasonable and necessary."

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

[2] Texas Labor Code 408.021