

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 Neuromuscular Institute of Texas – PA 9502 Computer Drive, Suite 100 San Antonio, Texas 78229	MDR Tracking No.: M5-05-2776-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address LP Box 17	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		
06-24-04	07-28-04	99213, E0191, A9300, 97140, 97035 and G0283	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
06-24-04	07-28-04	99212 and 98940	<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** prevail on the **majority** of disputed medical necessity issues. The amount due from the carrier for the medical necessity issues equals **\$872.38**.

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 07-18-05, 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.

CPT code 99205 date of service 07-01-04 denied with denial code "G" (global). Per the 2002 Medical Fee Guideline CPT code 99205 is not global to other services billed on date of service 07-01-04. Reimbursement is recommended in the amount of **\$205.39 (\$164.31 X 125%)**.

CPT code J2001 (2 units) date of service 07-01-04 denied with denial code "G" (global). Per the 2002 Medical Fee Guideline CPT code J2001 is not global to other services billed on date of service 07-01-04. Reimbursement is recommended in the amount of **\$2.20 (\$0.88 X 125% = \$1.10 X 2 units)**.

CPT code 99214 date of service 07-15-04 denied with with denial code "G" (global). Per the 2002 Medical Fee Guideline CPT code 99214 is not global to other services billed on date of service 07-01-04. Reimbursement is recommended in the amount of **\$96.91 (\$77.53 X 125%)**.

CPT code 99080-73 date of service 07-20-04 is listed on the table of disputed services. The respondent provided information that this service has been paid in the amount of \$15.00 (check number 06307833). This service is no longer in dispute and will not be part of the review.

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 \$1,176.88 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

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.

Parker Healthcare Management Organization, Inc.

3719 N. Beltline Road, Irving, TX 75038

972.906.0603 972.255.9712 (fax)

Certificate # 5301

August 11, 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: _____

RE: Independent review for M5-05-2776-01

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

- Parker Healthcare Management received notification of independent review on 7.15.05.
- Faxed request for provider records made on 7.19.05.
- The case was assigned to a reviewer on 7.29.05.
- The reviewer rendered a determination on 8.9.05.
- The Notice of Determination was sent on 8.11.05.

The findings of the independent review are as follows:

Questions for Review

Items in dispute: Established patient office visits, levels II and III (99212 & 99213), ultrasound therapy (97035), heel/elbow protector (E0191), exercise equipment (A9300), manual therapy techniques (97140), unattended electrical stimulation (G0283), and chiropractic manipulative therapy, spinal 1-2 areas (98940) for dates of service 6.24.04 through 7.28.04. Dates in dispute: 6.24.04-7.28.04

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 durable medical equipment (E0191 and A9300), the therapeutic ultrasound treatments (97035), the unattended electrical stimulation treatments (G0283), manual therapy techniques (97140), and the level III established patient office visit (99213) on 6/24/04 are all approved.

PHMO, Inc. physician reviewer has determined to **uphold the denial** of all services not specifically approved hereinbefore, specifically the level II established patient office visits (99212) and the chiropractic manipulative therapies, spinal 1-2 areas (98940).

Summary of Clinical History

Ms. ___ is a 45-year-old female, _____ for 23 years who, on ___, developed bilateral numbness and tingling in her hands while at work. She presented herself to a doctor of chiropractic on ___ and began conservative chiropractic care, including physical therapy. An EMG was ordered and revealed moderate-to-severe CTS on the left, and mild CTS on the right. Due to the patient's limited response to conservative management, a trial of Depo-Medrol injections were performed on 7.1.04 and again on 7.11.04, both followed by post-injection physical therapy.

Clinical Rationale

In this case, the records adequately documented that a compensable injury occurred to the patient's bilateral upper extremities. Therefore, it was medically necessary that the treating doctor periodically monitor the patient's progress through Evaluation and Management (99213), and

for him to prescribe appropriate durable medical equipment (E0191 and A9300). In addition, the patient received 2 injections by a pain management specialist and it was his post-injection recommendation and prescription that the patient receive supervised “e-stim, ultrasound, and soft tissue mobilization” (G0283, 97035 and 97140), so these treatments and procedures were also supported as medically necessary.

However, in terms of the level II established patient office visits (99212), nothing in either the diagnosis or the medical records submitted in this case supported the medical necessity for performing this level of Evaluation and Management service on each and every encounter (according to CPT 1), and particularly not during an already-established office visit, or while several other practitioners were also performing extensive evaluations on the patient.

And finally, in terms of the chiropractic manipulative treatment, spinal 1-2 areas (98940), performed on 7.19.04, nothing in either the diagnosis or the medical records that supported the performance of a *spinal* manipulative procedure for an upper extremity problem. In fact, on the contrary, the EMG specifically ruled out cervical involvement. Therefore, this service was unsupported as medically necessary.

Clinical Criteria, Utilization Guidelines or other material referenced

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

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 11th day of August, 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: Respondent

Requestor

Patient
