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: (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address: Park Cities Spine & Sports Center P. O. Box 549 Colleyville, Texas 76034	MDR Tracking No.: M5-05-2807-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Transcontinental Insurance Company, Box 47	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Many services were denied due to "V – Unnecessary Treatment with Peer Review. However, in the Peer Review it clearly states that some additional Physical Therapy modalities would be appropriate if the patient had further diagnostic studies. The doctor's report dated 11-09-04 supports the Peer Review doctors' discussion for further care. Regarding dates of service denied due to "E – entitlement to Benefits": this claim as since been found compensable.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

All the chiropractic services in dispute have been denied pursuant to the peer reviews. The claimant has had an excessive amount of chiropractic treatment. The medical records provided by the Requestor contain no supporting evidence for the necessity of additional chiropractic care. The claimant has spinal stenosis, an ordinary disease of life. Chiropractic treatment was not medically reasonable or necessary for this Claimant for such an extended period . The claimant has not shown any functional gains with the excessive amount of treatment rendered. The requestor has not provided evidence to support the billing codes of CPT code 97032 and 97110. Therefore, the respondent requests all fees with the CPT code 97110 and 97032 be immediately dismissed. The requestor has failed to establish the necessity for their excessive chiropractic treatments, no reimbursement is warranted.

PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
12-22-04 – 2-28-05	CPT codes 97110, 99212, 99213, 99214, 97535, 97032, 97140-59, 99070	☒ Yes ☐ No	$3,578.20

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 prevail on the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is $289.00.

Based on review of the disputed issues within the request, the 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 7-25-05 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.

Regarding CPT code 99213 on 12-23-04: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). Recommend reimbursement In accordance with 134.202(b) of $61.98.

CPT Regarding CPT code 97110 on 12-23-04 and 2-8-05: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). 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." 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 all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Reimbursement not recommended.

Regarding CPT code 97032 on 12-23-04: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). Recommend reimbursement of $18.73.

Regarding CPT code 99212 on 2-8-05: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). Recommend reimbursement of $45.26.

Regarding CPT code 99455-VR on 2-16-05: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). According to Rule 134.202 (6)(F) the treating doctor shall bill the medical disability examination with modifier "VR" to indicate a review of the report only, and shall be reimbursed $50.00. Recommend reimbursement of $50.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308

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 parties are instructed to review the IRO decision and take appropriate action. For any services that may have been found to be medically necessary, the insurance carrier is instructed to process those services through their bill review and payment processes, including issuing any additional amounts due consistent with the established fee guidelines. The carrier must refund the amount of the IRO fee within to the requestor within 30-days of receipt of this order. 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 additional reimbursement in the amount of $3,754.17. The Division hereby **ORDERS** the insurance carrier to remit this amount 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:

	Donna Auby	9-15-05
Authorized Signature	Typed Name	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.

NOTICE OF INDEPENDENT REVIEW DECISION

August 30, 2005

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker: ___
MDR Tracking #: M5-05-2807-01
IRO Certificate #: IRO4326

The TMF Health Quality Institute has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. TMF's health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 61 year old male injured his back on ___ while lifting a piece of office furniture. He has been treated with medications and therapy.

Requested Service(s)

Therapeutic exercises – 97710, office visits – 99213, 99214, 99212, self care management training – 97535, electrical stimulation – 97032, manual therapy technique – 97140-59, and supplies/material – 99070 for dates of service 12/22/04 through 02/28/05.

Decision

It is determined that the therapeutic exercises – 97710, office visits – 99213, 99214, 99212, self care management training – 97535, electrical stimulation – 97032, manual therapy technique – 97140-59, and supplies/material – 99070 for dates of service 12/22/04 through 02/28/05 were medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The patient was seen on 03/08/04 for evaluation by his new doctor and an MRI on 10/30/04 revealed significant problems. He was sent for an initial rehabilitation evaluation on 12/22/04 and an aggressive active treatment plan was begun. During the course of active rehabilitation he also received three lumbar epidural steroid injections from a pain management doctor. He was evaluated by a designated doctor on 02/04/05 and found not to be at maximum medical improvement. There is sufficient documentation of both subjective symptoms and objective findings on each date of service to clinically justify the treatment that was rendered. National treatment guidelines allow for this type of treatment for this type of injury. Appropriate treatment protocols were followed utilizing active rehabilitation in conjunction with lumbar epidural steroid injections.

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:dm

Attachment

Information Used by TMF in Decision

Patient Name: ___

TWCC ID #: **M5-05-2807-01**

Medical record documentation provided:

- **Progress Notes**
- **Designated Doctors Evaluation**
- **Diagnostic Tests**
- **Procedures**
- **Peer Review**
- **Consult**
- **Claims**