



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: South Coast Spine and Rehabilitation, P.A. 620 Paredes Line Road Brownsville, Texas 78521 | MDR Tracking No.: M5-05-2811-01 |
| | Claim No.: |
| | Injured Employee's Name: |
| Respondent's Name and Address: Texas Mutual Insurance Company Box 54 | Date of Injury: |
| | Employer's Name: |
| | Insurance Carrier's No.: |

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: TWCC-60, explanation of benefits, medical documentation and CMS 1500s

POSITION SUMMARY: The Texas Workers' Compensation Treatment Guidelines, even though they were abolished by the Texas Legislature on December 31, 2001, were used in conjunction with the treating physician professional experience to determine the patient's Phase of Care and diagnosis. These were used to determine the appropriate treatment for the patient. The treatment(s) and/or service(s) submitted to the carrier for the above listed date(s) of service(s) were based on the specific Phase of Care that corresponded to the patient at the time of the treatment(s) and/or service(s) in dispute.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to TWCC-60 and explanation of benefits

POSITION SUMMARY: This dispute involves the carrier's payment for date of service 1/12/2005 to 3/16/2005. The requester billed \$4,423.79; Texas Mutual paid \$1,977.61. The requester believes it is entitled to an additional of \$2,446.18

| Date(s) of Service | CPT Code(s) or Description | Medically Necessary? | Additional Amount Due (if any) |
|----------------------|--|---|--------------------------------|
| 01-12-05 to 03-16-05 | 97035 (1 unit @ \$14.63 X 12 units = \$175.56) | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$2,016.94 |
| | 97032 (1 unit @ \$18.73 X 12 units = \$224.76) | | |
| | 97124 (2 units @ \$52.56 X 11 DOS = \$578.16) | | |
| | 97113 (2 units @ 76.10 X 11 DOS = \$837.10) | | |
| | 97110 (1 unit @ \$33.56 X 6 DOS = \$234.92) | | |

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 **prevailed** on the disputed medical necessity issues. The amount due from the carrier for the medical necessity issues is noted above.

The requestor submitted an updated table of disputed services on 08-18-05. Code 99213 date of service 03-03-05 and code 97110 date of service 03-14-05 were verified as being paid and will not be a part of the review.

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 07-25-05, 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.

CPT code 99213 dates of service 03-07-05, 03-09-05, 03-10-05, 03-14-05 and 03-16-05 denied with denial codes –57- (payment denied/reduced because the payer deems the information submitted does not support this level of services, this many services, this length of service, this dosage or this day's supply) and –858- (physical medicine and rehabilitation services may not be reported in conjunction with an E/M code performed on the same day). Per the 2002 Medical Fee Guideline code 99213 can be reported in conjunction with the other services billed on the dates of service in dispute. In addition, the requestor submitted documentation that supports the services in dispute per Rule 133.307(g)(3)(A-F). Reimbursement is recommended in the amount of **\$309.45 (\$61.89 X 4 DOS)**.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and Rule 133.307(g)(3)(A-F)

PART VII: DIVISION DECISION AND 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 reimbursement in the amount of \$2,326.39. In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of \$460.00. 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:

Authorized Signature

09-26-05

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 North Belt Line Road, Irving, TX 75038
972.906.0603 972.906.0615 (fax)

September 7, 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: M5-05-2811-01
RE: Independent review for____

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

- Parker Healthcare Management received notification of independent review on 7.25.05.
- Faxed request for provider records made on 7.25.05.
- TWCC issued an Order for Documents from the respondent on 8.3.05.
- The case was assigned to a reviewer on 8.15.05.
- The reviewer rendered a determination on 9.6.05.
- The Notice of Determination was sent on 9.7.05.

The findings of the independent review are as follows:

Questions for Review

The disputed dates of service range from 1.12.05 thru 3.16.05. Those services in dispute are listed as 97035-Ultrasound, 97032-electrical muscle stimulation, 97124-massage therapy, 97113-aquatic therapy and 97110-therapeutic exercises. The disputed services on the table denied as "FEE" were not reviewed.

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 disputed service(s) except for the items listed below:

3.3.05- 99213
3.7.05- 99213
3.9.05- 99213
3.10.05- 99213
3.14.05- 99213
3.16.05- 99213

Summary of Clinical History

Mrs. ___ was injured while getting up from a rolling office chair that was on top of a plastic floor. Apparently, as Mrs. ___ was attempting to get into the chair it rolled out from underneath her and the injury occurred. There was pain reported in the lower back and the coccyx areas. The initial level of pain was noted to be a 6/10. The initial diagnoses were listed as 722.10, which is Lumbar HNP, 847.2 lumbar sprain and 724.7 facet syndrome. The date of injury was listed as _____. There were various re-examinations performed in order to offer outcomes assessment and tracking of patient progress. This was done over the given 2 months of treatment.

Clinical Rationale

During the time period in question, the patient demonstrated a reduction in pain from a 6 to a 1 on the VAS, range of motion increased in every plane of lumbar movement and the Oswestry scores reduced significantly. On 3.18.05, the patient was listed as having no restrictions and released back to full duty. It appears based upon what is available for review that the patient improved in every area and all aspects of the Texas labor code were achieved. This clearly makes the therapy in question reasonable. The therapy in question did not fall out of the reasonable time frames for usage and administration and the duration of treatment does not appear to be excessive. The therapy provided appears to be adequately documented.

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 7th 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.