

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 Real Health Care 12605 E. Fwy. Suite 507 Houston, TX 77015	MDR Tracking No.: M5-05-2822-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address American Home Assurance Company, Box 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

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

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
8-17-04	8-30-04	CPT code 99212 and 97140	<input checked="" type="checkbox"/> Yes <input 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 **prevailed** on the majority of the disputed medical necessity issues. The amount due the requestor for the medical necessity issues is \$514.49.

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 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 codes 97035 and 97032 on 7-19-04: 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). Per Rule 133.307 (e)(2)(A) the requestor must send a copy of all medical bills as originally submitted to the carrier for reconsideration in accordance with 133.304. Recommend no reimbursement.

CPT code 97035 on 7-21-04, 7-26-04, 7-27-04 and 7-28-04 was denied by the carrier as "N - Not appropriately documented." The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Recommend reimbursement of \$63.12 (\$15.78 X 4 DOS).

CPT code 97032 on 7-21-04, 7-26-04, 7-27-04 and 7-28-04, 8-13-04 was denied by the carrier as "N - Not appropriately documented." The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Recommend reimbursement of \$100.20 (\$20.04 X 5 DOS).

CPT code 97012 on 7-28-04 and 8-13-04 was denied by the carrier as "N - Not appropriately documented." The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Recommend reimbursement of \$38.20 (\$19.10 X 2 DOS).

CPT code 97032 on 8-4-04, 8-5-04, 8-6-04, 8-9-04, 8-10-04, 8-11-04, 8-12-04, 8-16-04, 8-17-04, 8-20-04, 8-23-04 was denied by the carrier as "713 - the charge exceeds the scheduled value and/or parameters that would appear reasonable." The MAR according to the 2002 MFG is \$20.04. Recommend reimbursement of \$220.44 (\$20.04 X 11 DOS).

CPT code 97140 on 8-9-04, 8-10-04, 8-11-04, 8-12-04, 8-16-04, 8-17-04, 8-20-04, 8-23-04, 8-25-04, 8-27-04 and 8-30-04 was denied by the carrier as "713 - the charge exceeds the scheduled value and/or parameters that would appear reasonable." Recommend reimbursement of \$373.01 (\$33.91 X 11 DOS).

CPT code 97140 on 8-13-04 was denied by the carrier as "434 - The value of this procedure is included in the value of the mutually exclusive procedure." Per the 2002 MFG CPT code 97140 is mutually exclusive to CPT code 97012 which was billed on this date of service. Recommend no reimbursement.

Regarding CPT code 97110 on 8-16-04, 8-17-04, 8-20-04, 8-23-04, 8-25-04, 8-27-04 and 8-30-04 which was denied by the carrier as "713 - the charge exceeds the scheduled value and/or parameters that would appear reasonable." 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.

PART IV: COMMISSION DECISION AND ORDER

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 \$1,309.46 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.

Ordered by:

Donna Auby

8-25-05

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 17, 2005

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

Re: Medical Dispute Resolution
MDR #: M5-05-2822-01
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
M5-05-2822-01

Information Provided for Review:

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

Information provided by Requestor

Correspondence

Office notes 07/19/04 – 09/20/04

Physical therapy notes 07/19/04 – 09/30/04

FCE 09/14/04

Radiology report 07/24/04

Information provided by Respondent:

Correspondence

Designated doctor review

Information provided by Pain Management Specialist:

Office note 07/26/04

Clinical History:

Records indicate that the patient was injured on the job while helping a coworker lift an entertainment set for a customer. Date of injury was _____. He was seen initially by a doctor for his injuries on 07/19/04.

Disputed Services:

Office visits and manual therapy technique during the period of 08/17/04 thru 08/30/04.

Decision:

The reviewer disagrees with the determination of the insurance carrier and is of the opinion that the office visits and manual therapy technique in dispute was medically necessary in this case.

Rationale:

As mentioned above, the patient was injured on the job on _____ while he was helping a coworker lift and move an entertainment set for a customer. The patient was seen for evaluation and a treatment program was begun on 07/19/04. Over the course of treatment, appropriate diagnostic testing in the form of x-rays and MRI scan was performed. In addition, the patient was referred for appropriate medication. Records indicate that the patient received passive therapy with progression to active therapy as tolerable. Treatment guidelines allow for this type of treatment for this type of injury. There is sufficient clinical documentation on each date of service rendered to justify the treatment that was provided. Records indicate that the patient improved both subjectively and objectively over the course of his treatment. The patient progressed to the point where a functional capacity evaluation was ordered, and the patient was released from care. In conclusion, office visits 99212 and manual therapy technique 97140 in dates of service 08/17/04 through 08/30/04 that were marked with a U denial were, in fact, reasonable, usual, customary, and medically necessary for the treatment of this patient's on-the-job injury.