



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:	MDR Tracking No.: M5-05-2825-01
Stephen Dudas 2800 Forestwood #130 Arlington, TX 76006	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:
Zurich American Insurance Company, Box 19	

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included TWCC 60 form, Explanations of Benefits, CARF accreditation, medical documentation and CMS 1500's. The position paper states that the designated doctor evaluation states that the patient has not yet reached MMI and that the patient could benefit from a Functional Capacity Evaluation and from a Work Hardening program.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The position summary states that, per peer review, these services are not reasonable or necessary.

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)
7-30-04 – 9-21-04	CPT codes 97110-GP, G0283, 97002	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,635.51

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 \$1,635.51.

Based on review of the disputed issues within the request, the 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.

Dates of service 4-23-04, CPT code G0283 on 8-25-04 and 8-30-04, CPT code 99080-73 on 9-21-04, 3 units of CPT code 97750-FC on 10-8-04 and CPT code 99080 on 11-23-04 were withdrawn by the requestor and will not be a part of this review.

On 7-15-05 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 97110-GP on the following dates:

7-30-04 - 2 units
8-4-04 - 4 units
8-6-04 - 1 unit
8-10-04 - 3 units
8-18-04 - 1 unit
8-20-04 - 2 units
8-31-04 - 3 units
9-2-04 - 2 units
9-7-04 - 1 unit
9-8-04 - 4 units

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 99080 on 7-28-04: The carrier states on its position paper that this service was reimbursed. However, the requestor states that he has not received payment. Recommend payment of \$50.00.

Regarding CPT code 97140-GP on 8-18-04: 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 \$32.90.

Regarding CPT code G0283 on 8-18-04: 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 \$ 13.90.

ding the work hardening program from 10-4-04 through 10-8-04: Either the carrier did not reimburse according to the CARF rate per Rule 134.202 (e)(5)(C)(ii) of \$64 per hour or 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 additional reimbursement of \$216.00.

Regarding 5 units of CPT code 97750-FC on 10-8-04: 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 \$186.25.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 134.202 and 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 carrier must refund the amount of the IRO fee (\$460.00) 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 \$2134.56. 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:

10-12-05

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.



Barton Oaks Plaza Two, Suite 200
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Phone 512-329-6610 - Fax 512-327-7159 - www.tmf.org

NOTICE OF INDEPENDENT REVIEW DECISION

September 1, 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 #: M5-05-2825-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) 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 39 year old female was involved in a work related injury on ___ when she injured her right shoulder to a degree that her rotator cuff was torn while working on the assembly line for _____. The patient underwent open surgery to her right shoulder and received chiropractic treatments from 07/30/2004 to 09/21/2004.

Requested Service(s)

Therapeutic exercises – 97110-GP, electrical stimulation (unattended) – G0283, and physical therapy re-evaluation – 97002 for dates of service of 07/30/2004 through 09/21/2004.

Decision

It is determined that the therapeutic exercises – 97110-GP, electrical stimulation (unattended) – G0283, and physical therapy re-evaluation – 97002 for dates of service of 07/30/2004 through 09/21/2004 were medically necessary to treat this patient's condition.

Rationale/Basis for Decision

Expectation 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 of objective and functional improvement in this patient's condition. Specifically, the patient's shoulder ranges of motion significantly increased from 06/20/2004 (before the disputed treatment) to 09/21/2004 (at the termination of the disputed treatment). Therefore, the medical records fully substantiate that the disputed services fulfilled the statutory requirements since promotion of recovery was accomplished.

Sincerely,



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

GBS:dm

Attachment

Information Submitted to TMF for TWCC Review

Patient Name: ____

TWCC ID #: M5-05-2825-01

Information Submitted by Requestor:

- Physical therapy progress notes
- Preauthorization requests
- X-ray reports
- Evaluations

Information Submitted by Respondent:

- Medical record reviews
- Office records
- Physical therapy evaluations and progress notes
- Operative reports
- Imaging reports
- Evaluations