



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: Southeast Health Services, Inc P O BOX 453062 Garland, Texas 75045	MDR Tracking No.: M5-05-2887-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Box 42	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60 package, CMS 1500s, explanations of benefits and medical documentation
 POSITION SUMMARY: Refer to the table of disputed services and Requestor's position

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60
 POSITION SUMMARY: Respondent did not submit a position summary

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
08-12-04 to 01-26-05	99211, 98940, 97012, 97032 and 97116	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00

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 not prevail** on the disputed medical necessity issues.

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 07-26-05, 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 99214-25 dates of service 07-02-04 and 07-19-04 denied with denial code "F84" (Fee Guideline MAR reduction). Per Rule 133.307(e)(2)(A) the requestor did not provide copies of CMS 1500s for review. No reimbursement is recommended.

CPT code 99354-25 date of service 07-05-04 denied with denial code "G90" (included in global). Per the 2002 Medical Fee Guideline code 99354-25 is not global to other services provided on the date of service in dispute. Reimbursement is recommended in the amount of **\$123.96**.

CPT code 97139-TN date of service 07-13-04 denied with denial code "G90" (included in global). Code 97139 is a valid code, however, modifier TN is not valid per the 2002 Medical Fee Guideline. No reimbursement recommended.

CPT code 99211 date of service 07-20-04 denied with denial code "F/84" (submit with the appropriate manipulation CPT code specific to the number of region/body/area(s) noted on the claim. Per Rule 133.307(g)(3)(A-F) the requestor submitted documentation supporting the service in dispute. Reimbursement is recommended in the amount of **\$27.86**.

CPT code 97110-59 date of service 08-02-04 and code 97110 dates of service 08-11-04, 08-17-04 and 08-18-04 denied with denial codes "G2" (included in global) and "F72" (fee guideline MAR reduction). The carrier has made no payment. In regard to date of service 08-02-04 denied as global, CPT code 97110-59 is global to CPT code 97113 billed on the same date of service. A modifier is allowed in order to differentiate between the services provided. Separate payment for the service billed may be considered justifiable if a modifier is used appropriately. However, 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". Documentation submitted by the Requestor does not clarify whether the services provided were 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 of all of the Commission requirements for proper documentation. No reimbursement is recommended. In regards to dates of service 08-11-04, 08-17-04 and 08-18-04 the documentation submitted as well does not clarify whether services provided were one-on-one. No reimbursement is recommended for these dates of service either.

CPT code 97032 dates of service 08-10-04 and 08-18-04 denied with denial code "F72" (Fee Guideline MAR reduction). The carrier has made no payment. Reimbursement is recommended in the amount of **\$40.40 (\$20.20 X 2 DOS)**.

CPT code 99080-73 dates of service 09-14-04, 10-05-04 and 10-19-04 denied with denial code "V" (unnecessary medical treatment with peer review). Per Rule 129.5 the DWC-73 is a required report which is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. Reimbursement is recommended in the amount of **\$45.00 (\$15.00 X 3 DOS)**.

CPT code 99455-V4-WP date of service 10-21-04 denied with denial code "V" (unnecessary medical treatment with peer review). Per Rule 134.202(E)(6)(B)(iii) this is a required service not subject to an IRO review. Reimbursement is recommended in the amount of **\$260.00**.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, Rules 129.5, 134.202(E)(6)(B)(iii), 133.307(e)(2)(A) and 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 additional reimbursement in the amount of \$497.22. The Division finds that the requestor was not the prevailing party and is not entitled to a refund of the IRO fee. 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.

Ordered by:

Authorized Signature

11-03-05

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.



PROFESSIONAL ASSOCIATES

NOTICE OF INDEPENDENT REVIEW

NAME OF PATIENT: _____
IRO CASE NUMBER: M5-05-2887-01
NAME OF REQUESTOR: Southeast Health Services, Inc.
NAME OF PROVIDER: Bryan Weddle, D.C.
REVIEWED BY: Board Certified in Chiropractics
IRO CERTIFICATION NO: IRO 5288
DATE OF REPORT: 09/01/05

Dear Southeast Health Services, Inc.:

Professional Associates has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO) (#IRO5288). Texas Insurance Code Article 21.58C, effective September 1, 1997, allows a patient, in the event of a life-threatening condition or after having completed the utilization review agent's internal process, to appeal an adverse determination by requesting an independent review by an IRO.

In accordance with the requirement for Texas Workers' Compensation Commission (TWCC) to randomly assign cases to IROs, TWCC has assigned your case to Professional Associates for an independent review. The reviewing physician selected has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, the reviewing physician reviewed 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. determination, and any documentation and written information submitted in support of the appeal.

This case was reviewed by a physician reviewer who is Board Certified in the area of Chiropractics and is currently listed on the TWCC Approved Doctor List.

I am the Secretary and General Counsel of Professional Associates and I certify that the reviewing physician 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 providers or any

of the physicians or providers who reviewed this case for determination prior to referral to the Independent Review Organization.

REVIEWER REPORT

Information Provided for Review:

An evaluation with Bryan Weddle, D.C. dated 07/02/04

Treatment with Dr. Weddle on 07/02/04, 07/05/04, 07/13/04, 07/19/04, 07/20/04, 08/02/04, 08/10/04, 08/11/04, 08/12/04, 08/16/04, 08/17/04, 08/18/04, 09/02/04, 09/03/04, 09/14/04, 10/05/04, 10/13/04, 10/19/04, 10/21/04, 01/08/05, 01/15/05, 01/22/05, and 01/26/05

An initial consultation with Charles Willis, II, M.D. dated 07/06/04

A follow-up evaluation dated 07/19/04 from Dr. Weddle

A Physical Performance Evaluation (PPE) dated 08/13/04 with Dr. Weddle

An EMG/NCV study of the lumbar spine and bilateral lower extremities dated 08/25/04 from Harold Marshall, M.D.

A Designated Doctor Evaluation by Dr. Marshall dated 08/25/04

A TWCC-69 form dated 08/25/04 and signed by Dr. Marshall

An MRI of the lumbar spine performed on 09/02/04 and interpreted by Ellis Robertson, M.D.

A follow-up evaluation dated 10/19/04 from Dr. Willis

An impairment rating from Dr. Weddle dated 10/21/04

A letter from Cindy Prieto, Business Administrator at Buddy Duncan & Associates

A letter of medical necessity for disputed services dated 06/17/05 from Dr. Weddle

A position statement from Robert F. Josey at Harris & Harris dated 08/03/05

Clinical History Summarized:

Dr. Weddle initially evaluated the claimant on 07/02/04 and therapy was prescribed. The claimant attended chiropractic therapy with Dr. Weddle from 07/02/04 through 01/26/05 and received Matrix treatment, ultrasound, mechanical traction, cold packs, and manipulative treatment. On 08/13/04, the claimant underwent a PPE with Dr. Weddle, which indicated the claimant was functioning in the light-medium physical demand level and his previous employment required the medium-heavy physical demand level. An EMG/NCV study on 08/25/04 was normal, according to Dr. Marshall, who also performed a Designated Doctor Evaluation on 08/25/04. He felt the claimant had not reached Maximum Medical Improvement (MMI). On 10/21/04, Dr. Weddle performed an impairment rating and assigned the claimant a 5% whole person impairment rating. Dr. Weddle addressed a letter of medical necessity for disputed services on 06/17/05 for reconsideration of payment. Mr. Josey, at Harris & Harris, provided a carrier's position statement on 08/03/05. He stated the carrier denied reimbursement, as the services provided by Dr. Weddle were neither reasonable nor necessary for the management of the claimant's injury.

Disputed Services:

Office visits, chiropractic manipulative treatment, mechanical traction, electrical stimulation, and gait training from 08/12/04 through 01/26/05

Decision:

I disagree with the requestor. The office visits, chiropractic manipulative treatment, mechanical traction, electrical stimulation, and gait training from 08/12/04 through 01/26/05 were neither reasonable nor necessary.

Rationale/Basis for Decision:

No. Basically, the question was whether the treatment provided to the claimant satisfied the qualifications of Section 408.021 of the Texas Labor Code. The code only substantiated the need for care, which cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment.

Based upon a review of the provided documentation, the claimant did suffer an injury in the lumbar spine, when it appeared to be a sprain/strain type injury. Based on the provided documentation, the claimant's condition did not appear to respond favorably to the provided aforementioned treatment. The documentation did not show that the claimant noted improvement following the ongoing conservative treatment and chiropractic manipulation. Therefore, it does not satisfy the section 408.021 of the Texas Labor Code. Therefore, the treatment provided between 08/12/04 and 01/26/05, including office visits, chiropractic manipulative treatment, mechanical traction, electrical muscle stimulation, and gait training would not be considered to be reasonable, medically necessary, or causally related to the original injury.

This review was conducted on the basis of medical and administrative records provided with the assumption that the material is true and correct.

This decision by the reviewing physician consulting for Professional Associates is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk **within twenty (20) calendar days** of your receipt of this decision (28 Texas Administrative Code 148.3).

This decision is deemed received by you **five (5) calendar days** after it was mailed and the first working day after the date this decision was placed in the carrier representative's box (28 Texas Administrative Code 102.5 (d)). A request for a hearing should be faxed to 512-804-4011 or sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P. O. Box 17787
Austin, TX 78744

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization's decision was sent to TWCC via facsimile or U.S. Postal Service on 09/01/05 from the office of Professional Associates.

Sincerely,

Lisa Christian
Secretary/General Counsel