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: Waco Ortho Rehab P. O. Box 2850 Bryan, Texas 77805	MDR Tracking No.: M5-05-2951-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: TX Mutual Insurance Company, Box 54	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included TWCC 60 form, Explanations of Benefits, medical documentation and CMS 1500's. Position summary stated, "The following excerpts form SOAH decisions relate that correct reimbursement for CPT 97750 is $43.00 per 15 minute unit, CPT 95851 is not global to office visits per SOAH decisions, office visits and other services were reasonable and necessary."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included TWCC 60 form and several Explanations of Benefits. The position summary states, "the carrier further asserts that it has properly completed the TWCC-60 form as required by rule 133.308."

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)
10-14-03 – 12-23-03	CPT codes 99212, 99213, 97110 (3 units per date), 97124	☒ Yes ☐ No	$607.10
10-14-03 – 12-23-03	97150, 98940, 98943, 99070 (biofreeze)	☐ Yes ☒ No	$0

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 majority of the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is $607.10.

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.

On 8-3-05 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 97750-MT on 10-14-03, 10-28-03, 11-11-03 and 11-18-03: In accordance with 134.202(b): for billing, reporting, and reimbursement of professional medial services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies. "MT" is not a valid modifier for this service. The requestor will be billed for inappropriate use of modifiers per Rules 134.202(b) and 134.202(e)(9). This service will not be part of this review.

CPT code 95851 on 10-14-03 and 11-18-03 was denied as "YG – reimbursement of this procedure is included in the basic allowance for another procedure." This code is considered by Medicare to be a component procedure of CPT code 99213. There are no circumstances in which a modifier would be appropriate. The services represented by the code combination will not be paid separately. Recommend no reimbursement.

CPT code 99213-25 on 10-15-03 was denied by the carrier as "JF – documentation submitted does not substantiate the service billed" and as "MU – Physical Medicine and Rehabilitation services may not be reported with an Evaluation and Management code performed on the same day". The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F) and per the 2002 MFG this service is not global to any other service performed on this date. The "25" modifier indicates that this is a "significant separate E/M by the same physician on the day of the procedure." Reimbursement of $58.99 is recommended.

CPT code 99070 on 10-15-03 and 10-29-03 was denied by the carrier as "YG – reimbursement for this procedure is included in the basic allowance for another procedure." Per the 2002 MFG this is a bundled code. Recommend no reimbursement.

CPT code 99080-73 on 10-15-03 was denied as "YO – reimbursement was reduced or denied after reconsideration." The TWCC-73 is a required report per Rule 129.5. The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Recommend reimbursement of $15.00.

CPT code 99211-25 on 10-17-03, 10-20-03, 10-22-03, 10-29-03, 11-07-03, 11-10-03, and 11-14-03 was denied by the carrier as "JF – documentation submitted does not substantiate the service billed" and as "MU – Physical Medicine and Rehabilitation services may not be reported with an Evaluation and Management code performed on the same day". The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F) and per the 2002 MFG this service is not global to any other service performed on this date. The "25" modifier indicates that this is a "significant separate E/M by the same physician on the day of the procedure." Recommend reimbursement of $163.45 ($23.35 X 7 DOS).

CPT codes 99212 and 99212-25 on 10-31-03, 11-11-03, 12-16-03 was denied by the carrier as "JF – documentation submitted does not substantiate the service billed" and as "MU – Physical Medicine and Rehabilitation services may not be reported with an Evaluation and Management code performed on the same day". The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F) and per the 2002 MFG this service is not global to any other service performed on this date. The "25" modifier indicates that this is a "significant separate E/M by the same physician on the day of the procedure." Recommend reimbursement of $125.73 ($41.91 X 3 DOS).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.202(b), 134.202(e)(9), 133.307(g) and 129.5.

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 Division has determined that the requestor is not entitled to a refund of the paid IRO fee. The Division has determined that the requestor is entitled to reimbursement in the amount of $970.27. 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.

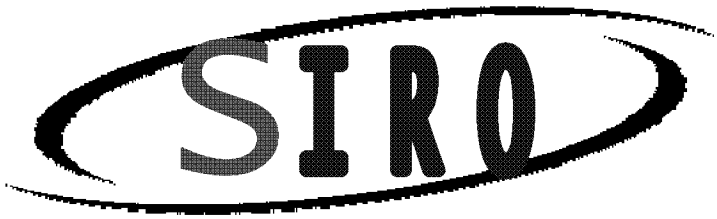
Findings and Decision and Order by:

		9-28-05
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.



Specialty Independent Review Organization, Inc.

August 29, 2005

TWCC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient: ___
TWCC #: ___
MDR Tracking #: M5-05-2951-01
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The

Texas Worker's Compensation Commission has assigned this case to Specialty IRO for independent review in accordance with TWCC Rule 133.308, which allows for medical dispute resolution by an IRO.

Specialty IRO has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Chiropractor. The reviewer is on the TWCC ADL. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

According to the records received and reviewed Mr. ___ was injured in a work related accident on ___ while working for . The injured employee was paving cement and stepped on a concrete vibrator, which caused him trip. The records reflect that he landed on his feet, twisting his knee but the vibrator fell over on his left foot. The injured employee was initially seen at Concentra and was later referred to Dr. Bryson. Later on April 9, 2003 Mr. ___ presented to Waco Ortho Rehab for treatment. The injured employee was initially diagnosed with ankle sprain/strain, knee sprain/strain, foot sprain/strain, and contusions. The patient later underwent a bone scan and was subsequently referred to Dr. Covington in late June. The injured employee had surgery to repair a nonunion fracture of the fifth left metatarsal on 7-11-2003. It should also be noted that the patient was involved in an unrelated MVA on 8-2-2003.

Numerous treatment notes, diagnostic tests, evaluations, and other documentation were reviewed. Records included but were not limited to the following:

Medical Dispute Resolution paperwork
Numerous EOB's
Summary Document by Dr. Bailey
Records from Waco Ortho Rehab
Multiple TWCC 73's
Employment Offer by Jack of All Trades Personnel
Records from Concentra Medical Centers
Reports from Hillcrest X-Ray Physicians
Records from Waco Bone & Joint Clinic
Records from hillcrest Baptist Medical Center
Designated Doctor report from Dr. Green on 12-08-2003
Service Analysis from Texas Mutual
FCE report from Injury 1 Treatment Center
Designated Doctor report from Dr. Blair on 3-09-2004

DISPUTED SERVICES

The items in dispute are the retrospective medical necessity of biofreeze-99070, office visists-99212-25 and 99213, therapeutic exercises-97110, massage-97124, group therapeutic procedures-97150 and chiropractic manipulations-98940 and 98943 from 10/14/2003 through 12/23/2003.

DECISION

The reviewer disagrees with the previous adverse decision regarding office visits 99212 and 99213 for the dates under review.

The reviewer disagrees with the previous adverse decision regarding therapeutic exercises 97110 for three units for the dates under review. The reviewer agrees with the previous adverse decision regarding therapeutic exercises 97110 for more than three units for any date of service under review. In other words, up to three units of 97110 for each date of service under review should be approved

The reviewer agrees with the previous adverse decision regarding group therapeutic exercises 97150 for the dates under review.

The reviewer agrees with the previous adverse decision regarding chiropractic manipulations 98940 and 98943 for the dates of service under review.

The reviewer disagrees with the previous adverse decision regarding massage 97124 for the dates under review.

The reviewer agrees with the previous adverse decision regarding Biofreeze 99070 for the dates of service under review.

BASIS FOR THE DECISION

The basis for the determination is based upon the Medical Disability Advisor, the Official Disability Guidelines, and Evidence Based Medicine Guidelines. In the supplied documentation, Dr. Bailey provides a litany of reports and medical evidence which are interesting and insightful but several of which are not relevant to this patient. The Medicare guidelines and payment policies were also utilized in the decision making process of this review. Medicare payment policies state, "for all PM&R modalities and therapeutic procedures on a given day, it is usually not medically necessary to have more than one treatment session per discipline. Depending on the severity of the patient's condition, the usual treatment session provided in the home or office setting is 30 to 45 minutes. The medical necessity of services for an unusual length of time must be documented." The treating doctor does not provide adequate documentation as to why the patient would need more than 45 minutes of combined rehabilitation per day.

This reviewer does grant the full 45 minutes of rehabilitation for each date of service and also would allow one unit of manual therapy in addition to the 45 minutes of rehabilitation due to the documented post-surgical status of the patient and the fact that lower extremity injuries are sometimes slow to heal given their weight bearing nature. The three units of therapeutic exercises and one unit of manual therapy would be medically necessary in Mr. ___'s case. The reviewer does have a concern with the protracted nature of the case and the fact that the surgery to the fracture of the foot occurred several months after the initial injury date but the post-surgical rehabilitation for the foot is clinically necessary.

In regards to the DME Biofreeze there is a notation in the documentation on 5-5-2005 that the Biofreeze did not relieve the patients pain. Based on this fact, there would be no reason to continue with prescribing the Biofreeze several months later. There are some notations of relief of pain temporarily but the notations are usually accompanied with the use of medications or alleve or the application of ice/heat but regardless there is no continued or long lasting effect from the balm and thus the medical necessity is not established.

In regards to the chiropractic manipulations to the spinal region, this is considered not medically necessary given the diagnosis and treatment plan of the patient. The spinal treatment would be unrelated to the patient's injuries. The extraspinal manipulations would be included in the approved office visits and would not be a separate and distinct procedure. The CPT code book includes the manipulation in the office visit unless there is a specific reason that it would not be included as part of the office visits. The documentation does not support a separate and distinct

manipulation from the office visit. In addition, performing extraspinal manipulations to the foot/ankle would not be clinically necessary given the post-surgical nature of the area. Any extraspinal manipulations delivered to the knee

would exceed the normative data established by the MDA for the time of service under this review based on the date of injury.

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that there is no known conflict between the reviewer, Specialty IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,

Wendy Perelli, CEO

CC: Specialty IRO Medical Director