



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.: M5-05-2953-01
SCD Back and Joint Clinic, Ltd. 200 E. 24 th Street, Suite B Bryan, Texas 77803	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Box 25	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 and CMS 1500's. Position summary (Table of Disputed Services) states, "The treatment and/or service was medically reasonable and necessary."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included TWCC 60 form and Explanations of Benefits. Position summary states, "Documentation does not support continued PT/Chiro care to documented WCI as medically 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)
11-19-03 – 6-1-04	CPT code 99211-25 X \$23.35 X 4 DOS	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$93.40
11-19-03 – 6-1-04	CPT code 99212-25 X \$41.91 X 5 DOS	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$209.55
11-19-03 – 6-1-04	CPT code 99213-25 X \$58.99 X 2 DOS	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$117.98
11-19-03 – 6-1-04	CPT code 99213 X \$58.99 X 4 DOS	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$235.96
11-19-03 – 6-1-04	CPT code 97110 X \$ X 52 units	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,690.00
11-19-03 – 6-1-04	CPT code 97150 X \$21.37 X 7 DOS	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$149.59
11-19-03 – 6-1-04	CPT code 97024 X \$5.53 X 5 DOS	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$27.65
11-19-03 – 6-1-04	CPT code 98943 X 12 DOS	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$335.64
11-19-03 – 6-1-04	CPT code 97124 X \$25.69 X 1 DOS	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$25.69
11-19-03 – 6-1-04	CPT code 95851 X \$30.60 X 1 DOS	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$30.60
11-19-03 – 6-1-04	CPT code 99080 X 1 DOS	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$134.50

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.

CPT code 98943 on all dates of service except 3-23-04 was denied for medical necessity. This code is in the CPT code book. It is not a bundled code and therefore it can be paid if it is medically necessary. The office visits billed on these dates of service contain the "25" modifier -SIGNIFICANT SEP E/M BY SAME PHYS ON DAY OF PRO.

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 \$3,050.56.

Regarding CPT codes 97139-EU and 97750-MT: In accordance with 134.202(b) for billing, reporting, and reimbursement of professional medical services, The Division of Workers' Compensation participants shall apply the Medicare program reimbursement methodologies. These modifiers are not valid per the 2002 MFG. Recommend no reimbursement for these services.

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

CPT code 98943 on 3-23-04 was denied by the carrier as "G - Unbundling." The office visit on the same day was justified with a 25 modifier. However, no medical notes were submitted in order to determine if this service was associated with another part of the body. No reimbursement recommended.

Regarding CPT code 99080-73 on 12-3-03, 12-22-03 and 1-5-04: The carrier denied these services with a "UN - Documentation fails to support medical necessity of continued treatment." In accordance with Rule 129.5, the requestor did not submit copies of the TWCC-73 (work status report) for these dates of service. Therefore, it cannot be determined if these reports were necessary. Recommend no reimbursement.

Regarding CPT code 99070 on 12-8-03 and 4-27-04: In accordance with 134.202(b) for billing, reporting, and reimbursement of professional medical services, the Division of Workers' Compensation participants shall apply the Medicare program reimbursement methodologies. Correct HCPC's codes are available for these supplies. Recommend no reimbursement for these services.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 129.5, 133.308 and 134.202(c)(1).

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 parties are instructed to review the IRO decision and take appropriate action. The carrier must refund the amount of the IRO fee (\$460.00) to the requestor within 30 days of receipt of this order. The requestor is entitled to reimbursement in the amount of \$3,050.56. 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:

11-22-05

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.

NOTICE OF INDEPENDENT REVIEW DECISION

October 10, 2005

Amended Letter: November 9, 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 #: M5-05-2953-01
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. The TMF physician reviewer has signed a certification statement that no known conflicts of interest exist between him or her and the provider, the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 44 year old female injured her right shoulder and arm on ___ while cleaning a shower wall at her place of employment. She has been treated with medications and therapy

Requested Service(s)

Office visits, therapeutic exercises, group therapeutic procedures, chiropractic manipulation, diathermy, message, range of motion, and record copies during the period of 11/19/2003 through 06/01/2004.

Decision

It is determined that the office visits, therapeutic exercises, group therapeutic procedures, chiropractic manipulation, diathermy, message, range of motion, and record copies during the period of 11/19/2003 through 06/01/2004 were medically necessary to treat this patient's condition.

Rationale/Basis for Decision

Medical record documentation indicated that the patient was injured on the job on ___ while she was scrubbing the walls of a walk-in shower, when she heard a pop in her right shoulder. She continued to clean the shower and developed severe, heavy pain. She reported to her supervisor and was instructed to see a doctor. She went to her family doctor who prescribed medications, an arm sling, and took x-rays of her right shoulder. This provided some relief but she was unable to take the medication while at work due to drowsiness. She was off work for two weeks and then returned to full duty work. She continued to have problems and requested a change of treating doctors from the TWCC. She was evaluated by the new physician and based upon the findings, an aggressive treatment program was begun. A MRI revealed significant findings but no specific tear. A specialist was consulted who injected the shoulder. She was referred for nerve conduction velocity testing and no significant abnormality was noted. Continued conservative care was recommended utilizing therapy. Periodic evaluations were done to confirm the need for additional care. Due to continual problems, surgery was recommended and performed on September 11, 2003. After surgery an aggressive post surgical rehabilitation program was begun. She was evaluated on December 16, 2003 and based upon testing, allowed to return to work part time based upon the recommended safe work capacity work status report. She was also referred to a center for chronic pain management. The documentation indicates that she was released to an as needed basis with regard to further treatment by her treating doctor. National treatment guidelines allow for this type of treatment for this type of injury. There is sufficient appropriate documentation on each date of service to clinically justify all of the above stated services for the period of 11/19/2003 through 06/01/2004.

Sincerely,

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

Information Used by TMF in Decision

Patient Name:

TWCC ID #: M5-05-2953-01

Medical record documentation provided:

- **Required Medical Examination**
- **Progress Notes**
- **Procedures**
- **Diagnostic Tests**
- **Durable Medical Equipment**
- **Claims**