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.: M5-05-3016-01
Summit Rehabilitation Centers P.O. Box 380395 Ft. Worth, TX 76102	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
Ace American, Box 15	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, "Per Rule 133.304 (c) At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The insurance carrier has failed to follow this rule as no EOB's were received for many services which were billed."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included TWCC 60 Provider's List, and some Explanations of Benefits. The position summary stated, "The carrier believes the provider is not entitled to reimbursement for travel expenses. The missing EOBs are in Attachment 2."

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)
7-19-04 – 8-17-04	CPT codes 97140, A4556, G0283, 97110, 99213	☒ Yes ☐ No	$550.92
8-18-04 – 11-17-04	CPT codes 97140, A4556, G0283, 97110, 99213	☐ Yes ☒ No	-0-
7-19-04 – 11-17-04	CPT codes 99199, 95851, 95831, 96004, E0730	☐ 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 $550.92.

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 8-9-05 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.

Per Rule 134.6 travel (CPT code 99082) is not under the jurisdiction of Medical Dispute Resolution. These services will not be a part of this review.

CPT code 99080-73 on 7-19-04 was denied as "86-the provider billed for a Work Status Report on a subsequent date of service." The requestor presented no supporting documentation to the contrary. Recommend no reimbursement.

CPT code 95851 on 7-20-04 and 10-4-04 was denied as "YG or 435 - the services are included in a more comprehensive procedure." Per the 2002 MFG this service is a component procedure of CPT code 97140 which was billed on this date of service. No reimbursement recommended.

CPT code 96004 on 7-20-04 and 11-17-04 was denied as "YG - the services are included in a more comprehensive procedure" and/or as "JM-the code and/or modifier billed is invalid." Per the 2002 MFG this service is not a component procedure of any code which was billed on this date of service. This is a valid code per the 2002 MFG. Recommend reimbursement of $305.50 ($152.75 X 2 DOS).

CPT code 99213 on 7-23-04, 7-27-03, 8-2-04, 8-9-04, 8-10-04, 8-12-04, 8-24-04, 8-25-04, 9-1-04, 9-2-04 and 9-21-04 was denied as "N – documentation submitted does not substantiate the service billed" and/or as " 12 - the provider billed for the service on the same day as a physical therapy procedure." Per the 2002 MFG the criteria for this service is: "requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs." Review of the office notes submitted show that the documentation criteria set forth by the CPT Code descriptor is supported. Per the 2002 MFG this service is not a component procedure of any code which was billed on these dates of service. Recommend reimbursement of $750.64 ($68.24 X 11 DOS).

CPT code 96004 on 8-10-04 was denied as "N – documentation submitted does not substantiate the service billed." Per the 2002 MFG the criteria for this service is "The physician reviews and interprets computer-based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography performed using codes." Review of the office notes submitted show that the documentation criteria set forth by the CPT Code descriptor is supported. Recommend reimbursement of $152.75.

CPT code 97140 on 8-10-04 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 $34.13.

CPT code G0283 on 8-11-04 was denied by the carrier as "287-the doctor is not on the approved doctor's list." MDR verified that this doctor is on the approved doctor's list. Recommend reimbursement of $34.13.

CPT code 99080-73 on 8-16-04 and 9-14-04 was denied as "TD -Work Status Report was not properly completed or was submitted in excess of filing requirements." Per Rule 129.5 the report was submitted correctly. Recommend reimbursement of $30.00 ($15.00 x 2 DOS).

CPT code 97110 on 8-18-04, 8-24-04, 9-2-04, 9-22-04, services was denied as TK-Rule requires submission of legible supporting documentation." Or as 01-the charge for the procedure exceeds the amount indicated in the fee schedule. 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.

CPT code G0283 on 8-18-04 was denied as TK-Rule requires submission of legible supporting documentation." The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Recommend Reimbursement of $14.41.

CPT code 99199 on 9-9-04 was denied as "JM- Accurate coding of services rendered is essential." Per the criteria of the 2002 MFG this service was not coded correctly. Recommend no reimbursement.

CPT code 97140 on 9-22-04 was denied as "213-the charge exceeds the scheduled value." Per the 2002 $34.13 is the correct fee. Recommend Reimbursement of $34.13.

CPT code 99199 on 10-12-04 was denied by the carrier as "287-the doctor is not on the approved doctor's list." The doctor is on the Approved Doctor List. Recommend reimbursement of $35.00.

CPT code 99213 on 10-12-04 was denied by the carrier as "790-the charge was reduced per the Medical Fee Guideline. The carrier has paid $62.81. Additional reimbursement recommended - $5.43.

CPT code G0283 on 10-12-04 was denied by the carrier as "790-the charge was reduced per the Medical Fee Guideline. The carrier has paid $13.59. Additional reimbursement recommended - $.82.

CPT code 95831 on 11-2-04 was denied as "435 - the value of this procedure is included in a more comprehensive procedure." Per the 2002 MFG this service is a component procedure of CPT code 99213 which was billed on this date of service. No reimbursement recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.600, 133.307(g)(3)(A-F), 2002 MFG, 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. 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 $1,947.86. 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:

		9-21-05
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.

September 6, 2005

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

Re: Medical Dispute Resolution
MDR #: M5-05-3016-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: IRO 5055

Dear Ms. ___:

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 chriopractic, and is currently on the TWCC Approved Doctor List.

Sincerely,

Gilbert Prud'homme
General Counsel

GP:dd

REVIEWER'S REPORT
M5-05-3016-01

Information Provided for Review:
TWCC-60, Table of Disputed Services, EOB's
Information provided by Requestor:
Medical Necessity Letter
Behavioral Medicine Eval 07/30/04
PT Notes 07/19/04 – 11/17/04
Functional Capacity Eval 08/04/04 – 11/02/04
Radiology Report 07/29/04
Information provided by Respondent:
Correspondence
Designated Review

Pain Management:
Office Notes 07/20/04 – 10/12/04
Orthopedist:
Office Notes 08/20/04 – 12/01/04

Clinical History:
Patient underwent extensive physical medicine treatments after injuring her right shoulder at work on ___ when she lost her balance and fell against a metal shelf behind her.

Disputed Services:
Manual therapy technique, Office visits, unlisted special service, electrodes, ROM, electrical stimulation, muscle testing, therapeutic exercises, physician review and interpretation of comprehensive computer based motion analysis, and TENS supplies. from 07/19/04 through 11/17/04.

Decision:
The reviewer partially agrees with the determination of the insurance carrier in this case. All 97140 – manual therapy technique, all A4556 – electrodes, all G0283 – electrical stimulation, all 97110 – therapeutic exercises from 07/19/04 through 08/17/04 are medically necessary. The 99213 - office visit on 08/17/04 is also approved. All other examinations, treatments and procedures are not medically necessary in this case.

Rationale:
The *Guidelines for Chiropractic Quality Assurance and Practice Parameters* 1 Chapter 8 under "Failure to Meet Treatment/Care Objectives" states, "After a maximum of two trial therapy series of manual procedures lasting up to two weeks each (four weeks total) without significant documented improvement, manual procedures may no longer be appropriate and alternative care should be considered." Based on those guidelines, certain specified treatments would have been reasonable for a period of 4 weeks, but not afterward.

Physical medicine is an accepted part of a rehabilitation program following an injury. However, for medical necessity to be established, there must be an expectation of recovery or improvement within a reasonable and generally predictable time period. In addition, the frequency, type and duration of services must be reasonable and consistent with the standards of the health care community. Expectation of improvement 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. In this case, there is no documentation of objective or functional improvement in this patient's condition.

In general, most computerized documentation, regardless of the software used, fails to provide individualized information necessary for reimbursement. The Center for Medicare and Medicaid Services (CMS) has stated, "Documentation should detail

the specific elements of the chiropractic service for this particular patient on this day of service. It should be clear from the documentation why the service was necessary that day. Services supported by repetitive entries lacking encounter specific

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1 Haldeman, S; Chapman-Smith, D; Petersen, D *Guidelines for Chiropractic Quality Assurance and Practice Parameters,* Aspen Publishers, Inc.

information will be denied." In this case, there is insufficient documentation to support the medical necessity for the treatment in question since the computer-generated daily progress notes were for the most part identical for each date of service.

According to the Medicare Guidelines, if a patient's expected restoration potential is insignificant in relation to the extent and duration of the physical medicine services required to achieve such potential, the services are not considered reasonable or necessary.

Most importantly, the records failed to substantiate that the disputed services fulfilled statutory requirements 2 for medical necessity since the patient obtained no relief from the treatments (pain rating of 6/10 on 07/19/04 at the initiation of care and a pain rating of 6/10 on 08/17/04 at the 4-week point), promotion of recovery was not accomplished and there was no enhancement of the employee's ability to return to or retain employment. The claimant's complete lack of response was also documented by the provider's daily treatment notes, which stated on each and every date of service, *"Alba's condition has stayed about the same since her last visit to the clinic."*

And finally, based on CPT 3, there is no support for the medical necessity for the high level of E/M service (99213) on most every visit during an established treatment plan.

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2 Texas Labor Code 408.021

3 *CPT 2004: Physician's Current Procedural Terminology, Fourth Edition, Revised.* (American Medical Association, Chicago, IL 1999),