



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: Summit Rehabilitation Centers 2500 W. Freeway #200 Ft. Worth, TX 76102	MDR Tracking No.: M5-05-3071-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: American Zurich Insurance Company, Box 19	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. The position summary states, "TWCC Rule 133.304(c) states, carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s). A generic statement that simply states a conclusion such as "not sufficiently documented" or other similar phrases with no further description of the reason for the reduction or denial of payment does not satisfy the requirements of this section. Carrier has failed to follow this rule."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included TWCC 60 form and peer reviews. The position summary states, "The carrier disputes that the provider has shown that the treatment underlying the charges was medically reasonable and necessary. The carrier asserts that it has paid according to applicable fee guidelines. The documentation provided does not establish medical necessity. The provider must establish entitlement to reimbursement in accordance with the TWCC MFG."

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)
9-29-04 – 1-11-05	CPT codes 99213, 72040, 97750-FC, 97545-WH 97546-WH	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2,481.84
9-29-04 – 2-17-05	CPT codes G0283, 97012, 99204, 97110, 97140-59, 98940, 96004	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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 prevail on the majority of the

disputed medical necessity issues. The total amount due the requestor for the medical necessity services is \$2,481.84.

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.

On 8-17-05 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.

The carrier denied CPT Code 99080-73 on 10-29-04 and 1-31-05 a "V" for unnecessary medical treatment based on a peer review; however, the TWCC-73 is a required report per Rule 129.5 and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. Recommend reimbursement of \$30.00 (\$15.00 X 2 DOS).

Regarding CPT code 97545-WH and 97546-WH on 12-29-04, 2-10-05, 2-11-05, 2-15-05, 2-16-05, and 2-17-05: 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 \$2,201.60.

Regarding CPT code 97545-WH and 97546-WH on 2-9-05: The carrier denied these services as "not appropriate health care provider." These services were performed by an "appropriate health care provider" who is on the Division's Approved Doctor List. Recommend reimbursement of \$358.40.

Regarding CPT code 99213 on 1-27-05: 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 \$68.24.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.202(b) and 134.202 (e) (5) (A) (ii).

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 within to the requestor within 30 days of receipt of this order. Division has determined that the requestor is entitled to additional reimbursement in the amount of \$5,140.08. 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 by:

_____	Donna Auby	10-18-05
Order by: _____	_____	_____
_____	Margaret Ojeda	10-18-05
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 30, 2005

**ATTN: Program Administrator
Texas Workers Compensation Commission**

Medical Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100
Austin, TX 78744
Delivered by fax: 512.804.4868

Notice of Determination

MDR TRACKING NUMBER: M5-05-3069-01
RE: Independent review for ____

The independent review for the patient named above has been completed.

- Parker Healthcare Management received notification of independent review on 8.19.05.
- Faxed request for provider records made on 8.22.05.
- TWCC issued an Order for Payment on 8.31.05.
- The case was assigned to a reviewer on 9.9.05.
- The reviewer rendered a determination on 9.28.05.
- The Notice of Determination was sent on 9.30.05.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of the following services: G0283- Electrical Stimulation, 97032- Electrical Stimulation Manual, 97035- Ultrasound, 97110- Therapeutic Exercises, 97140- Manual Therapeutic Technique, 99213 and 99214- Office visits, 97530- Therapeutic Activities, and 97018- Paraffin Bath

Dates of service for review: 9.07.04 through 03.24.05; items marked as FEE were not reviewed

Determination

PHMO, Inc. has performed an independent review of the proposed care to determine if the adverse determination was appropriate. After review of all medical records received from both parties involved, the PHMO, Inc. physician reviewer has determined to **overturn the denial** on denied CPT code 97110-therapeutic exercises from 9.07.2004-10.27.2004.

The PHMO, Inc. physician reviewer has also determined to **uphold the denial** on all other service codes during the review period of 9.07.04-3.24.05. This would include codes:

G0238, 97032, 97035, 97140, 99213/99214, 97530, 97018 and 97110 (from 10.29.04-3.24.05)

Summary of Clinical History

The claimant underwent passive therapy, active physical medicine treatments and injections after reporting a wrist injury to her supervisor on ____.

Clinical Rationale

The designated doctor reported that no active treatment had been performed prior to 09.07.04 and further related that the claimant improved during the first two months of the disputed treatment. Therefore, based solely on the designated doctor's report, it is reasonable to assume that active treatment was medically indicated and beneficial during that time frame. For that reason, all 97110 therapeutic exercises from 9.07.04 through 10.27.04 are approved as medical indicated.

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. General expectations include: (A) As time progresses, there should be an increase in the active regimen of care, a decrease in the passive regimen of care and a decline in the frequency of care. (B) Home care programs should be initiated near the beginning of care, include ongoing assessments of compliance and result in fading treatment frequency. (C) Patients should be formally assessed and re-assessed periodically to see if the patient is moving in a positive direction in order for the treatment to continue. (D) Supporting documentation for additional treatment must be furnished when exceptional factors or extenuating circumstances are present. (E) Evidence of objective functional improvement is essential to establish reasonableness and medical necessity of treatment. 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 and no evidence of a change of treatment plan to justify additional treatment in the absence of positive response to prior treatment.

Specifically in regard to the 99213 and 99214 office visits, there is no support under CPT 1 for the medical necessity for this high level of E/M service on each and every visit during an established treatment plan.

Clinical Criteria, Utilization Guidelines or other material referenced

This conclusion is supported by the reviewers' clinical experience with over 8 years of patient care.

The reviewer for this case is a doctor of chiropractic peer matched with the provider that rendered the care in dispute. The reviewer is engaged in the practice of chiropractic on a full-time basis.

The review was performed in accordance with Texas Insurance Code §21.58C and the rules of the Texas Workers Compensation Commission. In accordance with the act and the rules, the review is listed on the TWCC's list of approved providers, or has a temporary exemption. The review includes the determination and the clinical rationale to support the determination. Specific utilization review criteria or other treatment guidelines used in this review are referenced.

The reviewer signed a certification attesting that no known conflicts-of-interest exist between the reviewer and any of the providers or other parties associated with this case. The reviewer also attests that the review was performed without any bias for or against the patient, carrier, or other parties associated with this case.

Your Right To Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District

¹ CPT 2004: *Physician's Current Procedural Terminology, Fourth Edition, Revised*. (American Medical Association, Chicago, IL 1999),

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.

If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision. The address for the Chief Clerk of Proceedings would be: P.O. Box 17787, Austin, Texas, 78744.

I hereby verify that a copy of this Findings and Decision was faxed to TWCC, Medical Dispute Resolution department applicable to Commission Rule 102.5 this 30th day of September, 2005. The TWCC Medical Dispute Resolution department will forward the determination to all parties involved in the case including the requestor, respondent and the injured worker. Per Commission Rule 102.5(d), the date received is deemed to be 5 (five) days from the date mailed and the first working day after the date this Decision was placed in the carrier representative's box.

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.