



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: Dr. Brad Burdin 9502 Computer Drive Suite 100 San Antonio, Texas 78229	MDR Tracking No.: M5-05-3097-01
	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, medical documentation and explanations of benefits
POSITION SUMMARY: "These treatments were provided based on doctor's professional judgment" from the table of disputed services.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60, explanations of benefits, CMS 1500s
POSITION SUMMARY: Enclosed herein is documentation supportive of the Self-Insured's position on this matter. The services at issues were not medically necessary for the management of the claimant's compensable injury, hence merit no reimbursement.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
07-26-04 to 10-01-04	G0283 (\$13.41 X 16 = \$214.56) 97035 (\$14.81 X 15 = \$222.15) 97140 (\$31.73 X 7 = \$222.11) A4556 (\$50.00 X 1 = \$50.00)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$708.82

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 **prevailed** on the disputed medical necessity issues. The amount due from the carrier for the medical necessity issues equals \$708.82.

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 08-29-05, 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 133.308(e)(1) date of service 07-23-04 code 99213 was not timely filed and is ineligible for review.

CPT code 97140 dates of service 07-26-04, 07-29-04, 08-02-04, 08-10-04, 08-19-04, 08-20-04, 08-23-04 and 08-26-04 was denied by the carrier as "duplication of treatment when performed to same area as MP". Per the 2002 Medical Fee Guideline CPT code 97140 is considered to be a component procedure of code 98940 billed on each date of service in dispute. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be considered justifiable if a modifier is used appropriately. The requestor did not bill the services with a modifier. No reimbursement recommended.

CPT code 99213 date of service 08-06-04 was denied by the carrier with denial code "N" (payment reduced/denied because medical to support need for OV not established). Per Rule 133.307(g)(3)(A-F) the requestor submitted documentation to support the service in dispute. Reimbursement is recommended in the amount of **\$61.98**.

CPT code 99212 dates of service 09-29-04, 09-30-04 and 10-01-04 was denied by the carrier with denial code "N" (payment reduced/denied because medical to support need for OV not established). Per Rule 133.307(g)(3)(A-F) the requestor submitted documentation to support the service in dispute. Reimbursement is recommended in the amount of **\$132.48 (\$44.16 X 3 DOS)**.

CPT code 97140 date of service 08-30-04 was denied by the carrier as a "duplication of treatment when performed to same area as 98940". Per the 2002 Medical Fee Guideline CPT code 97140 is considered to be a component procedure of code 98940 billed on the date of service in dispute. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be considered justifiable if a modifier is used appropriately. The requestor did not bill the service with a modifier. No reimbursement recommended.

CPT code G0283-GP date of service 08-30-04 was denied by the carrier as "this modality is to be performed in conjunction with therapeutic procedures." Per the 2002 Medical Fee Guideline the service in dispute is not required to be provided along with therapeutic procedures. Reimbursement is recommended in the amount of **\$13.41**.

CPT code 97035-GP date of service 08-30-04 was denied by the carrier as "this modality is to be performed in conjunction with therapeutic procedures." Per the 2002 Medical Fee Guideline the service in dispute is not required to be provided along with therapeutic procedures. The MAR for code 97035-GP is \$14.81, however, the requestor listed the amount in dispute on the table of disputed services as \$13.41. Reimbursement is recommended in the amount of **\$13.41**.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, Rules 133.308(e)(1), 133.307(g)(3)(A-F) and 134.202(c)(1)

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 reimbursement in the amount of \$930.10. In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of \$460.00. 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:

11-03-05

Authorized Signature

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: M5-05-3097-01
RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 8.29.2005.
- Faxed request for provider records made on 8.31.2005.
- The case was assigned to a reviewer on 9.15.2005.
- The reviewer rendered a determination on 9.28.2005.
- The Notice of Determination was sent on 9.30.2005.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of Electrical stimulation, unattended (G0283), ultrasound (97035), manual therapy technique (97140), and durable medical equipment (electrodes A4556) for dates of service 7.26.04 through 10.01.04. 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 the requested service(s).

Summary of Clinical History

Patient is a 47-year-old diabetic paramedic with past history of spinal fusion at L5-S1 who, on ____, was lifting a 400-pound patient and immediately experienced lower back and left leg pain. He presented himself to a doctor of chiropractic, who initiated physical therapy and mobilization, but when the response was less than desired, he was referred for additional diagnostics. A lumbar MRI revealed multilevel lumbar spondylosis, most advanced at L4-5, with mild effacement of the thecal sac and canal stenosis. In addition, it revealed a far left lateral disc protrusion "and/or disco-osteophytic complex at L1-2." Thereafter, an EMG/NCV revealed a non-acute left L5 radiculopathy.

The patient then underwent trigger point injections, SI joint injections and S2 nerve blocks, followed by post-injection physical therapy. A designated doctor on 6/3/05 also saw the patient, and it was his opinion that the patient was not at MMI and, in fact, needed surgical intervention.

Clinical Rationale

In this case, the medical records adequately documented that the patient sustained a significant injury to his lower back. In addition, the records also reflected that the patient was experiencing significant pain, muscular spasms, and sustained marked range of motion deficits as a result of the injury. The records documented that the case was complicated by the patient's diabetes and previous back surgery, both of which would necessitate a protracted treatment time when compared to other injuries absent such complications (easily through 10.01.04). Therefore, since the medical records also substantiated that the disputed services fulfilled the statutory requirements¹ for medical necessity because the patient obtained relief secondary to their utilization, they are approved.

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 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.