



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.: M5-05-3103-01
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:	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:
American Home Assurance Company, Box 19	

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 states, "All supplies are reasonable and necessary. This office billed correctly per TWCC guidelines and MAR. Treatment was reasonable and necessary." The requestor states that no further payments were received from the carrier on items on the Table of Disputed Services.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included TWCC 60 form. Position summary states, "A review of our file shows payments for DOS 8-6-04 -11-30-04. Attached are "Payment history" printouts.

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)
8-6-04 – 11-30-04	CPT codes 98940, 98941, 98943, 97012, 97124, 97750-MT, 3 units of 97110 for each DOS, 1 unit of 97112 for each DOS	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2,578.67
8-6-04 – 11-30-04	CPT codes 97018, 97150, 97530, more than 3 units of 97110 for each DOS, more than 1 unit of 97112 for each DOS	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

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 disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$2,578.67.

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 8-23-05 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.

CPT code 97139-EU is not a valid code per the 2002 MFG. This service will not be a part of this review.

HCPCS code A9150 on 8-6-04 and 11-30-04 was denied by the carrier as "F – fee guideline MAR reduction." Texas Labor Code 413.011 (d) and Rule 133.304 (i) (1-4) place certain requirements on the Requestor when billing for services for which the Commission has not established a maximum allowable reimbursement. Per Rule 133.307(g)(3)(D), the Requestor is required to discuss, demonstrate and justify that the payment being sought is a fair and reasonable rate of reimbursement. The Requestor has provided sample EOBs as evidence that the fees billed are for similar treatment of injured individuals and that reflect the fee charged to and paid by other carriers. Recommend reimbursement of \$16.00.

HCPCS code L1499 on 8-18-04 was denied by the carrier as "F – fee guideline MAR reduction." Texas Labor Code 413.011 (d) and Rule 133.304 (i) (1-4) place certain requirements on the Requestor when billing for services for which the Commission has not established a maximum allowable reimbursement. Per Rule 133.307(g)(3)(D), the Requestor is required to discuss, demonstrate and justify that the payment being sought is a fair and reasonable rate of reimbursement. The Requestor has not provided sample EOBs as evidence that the fees billed are for similar treatment of injured individuals and that reflect the fee charged to and paid by other carriers. Recommend no reimbursement.

CPT code 97124 on 8-9-04, 8-10-04, 9-1-04, 9-2-04, 9-7-04, 9-10-04, 9-13-04, 9-14-04, 9-27-04 and 10-4-04 was denied by the carrier as "G-Unbundling". According to the 2002 MFG this procedure is considered by Medicare to be a component procedure of CPT code 98940, 98941, or 97150. Recommend no reimbursement.

CPT code 97018 on 8-12-04, 8-19-04, 9-1-04, 9-9-04, 9-14-04, 9-29-04, 10-01-04 was denied by the carrier as "G-Unbundling". According to the 2002 MFG this procedure is considered by Medicare to be a component procedure of CPT code 97012. Recommend no reimbursement.

CPT code 97112 on 8-13-04, 8-16-04, 8-17-04, 8-18-04, 8-19-04, 9-1-04, 9-3-04, 9-7-04, 9-9-04, 9-10-04, 9-13-04, 9-14-04, 9-15-04, 9-22-04, 9-24-04, 9-27-04, 10-04-04 was denied by the carrier as "G-Unbundling". According to the 2002 MFG this procedure is considered by Medicare to be a component procedure of CPT code 98940 and 98941. Recommend no reimbursement.

CPT code 95851 on 8-25-04 was denied by the carrier as "G-Unbundling". According to the 2002 MFG this procedure is considered by Medicare to be a component procedure of CPT code 99213. Recommend no reimbursement.

CPT code 97530 on 9-9-04, 9-10-04, 9-13-04, 9-14-04, 9-15-04 and 9-22-04 was denied by the carrier as "G-Unbundling". According to the 2002 MFG this procedure is considered by Medicare to be a component procedure of CPT code 97150. Recommend no reimbursement.

CPT code 97110 on 9-24-04 and 9-27-04 was denied by the carrier as "G-Unbundling". According to the 2002 MFG this procedure is considered by Medicare to be a component procedure of CPT code 97150. Recommend no reimbursement.

CPT code 97124 on 10-1-04 was denied by the carrier as "G-Unbundling." According to the 2002 MFG this procedure is considered by Medicare to be a component procedure of CPT code 97150. Recommend no reimbursement.

Regarding CPT code 98940 on 10-15-04: 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 \$30.13.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308

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 Division has determined that the requestor is entitled to additional reimbursement in the amount of \$2,624.80. 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:

10-6-05

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.

September 9, 2005

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

Patient: ____
TWCC #:
MDR Tracking #: M5-05-3103-01
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 _____. The patient was working for _____ as a pool painter when he was injured. According to the records Mr. ____ was working when he fell into an empty pool. Mr. ____ was immediately taken to the emergency room for care and then Mr. ____ when to Scott & White Occupational Medicine. Later Mr. ____ presented to The Back & Joint Clinic for follow-up treatment on 8-5-2004. Upon presentation to The Bone & Joint Clinic Mr. ____ were complaining of neck, back, right wrist, right and left shoulder, and left knee pain. Mr. ____ also reported headaches and loss of memory.

RECORDS REVIEWED

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
Letter from Broadspire 8-24-2005
Payment History from Broadspire
Summary Letter from The Back & Joint Clinic
Records from The Back & Joint Clinic
Lumbar MRI from Brazos Valley Open MRI and Diagnostic Center
Cervical MRI from Brazos Valley Open MRI and Diagnostic Center

Right Wrist MRI from Brazos Valley Open MRI and Diagnostic Center

Records from Dr. Light
Records from Pain & Wellness Clinic
Records from The Suchowiecky Center
Report from Dr. Pollock
Multiple Appendices referencing various literature

DISPUTED SERVICES

Disputed services include the following: 98940, 98941, 98943 Chiropractic Manipulation, 97750-MT Muscle Testing, 97012 Mechanical Traction, 97124 Massage, 97018 Paraffin Bath, 97150 Group Therapeutic Procedures, 97112 Neuromuscular Reeducation, 97530 Therapeutic Activities and 97110 Therapeutic Exercises from 9/1/04 through 11/22/04.

DECISION

The reviewer disagrees with the previous adverse decision regarding 98940, 98941, 98943 for all dates of service 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 97018, 97150 and 97530.

The reviewer disagrees with the previous adverse decision regarding 97012, 97124 and 97750-MT.

The reviewer disagrees with the previous adverse decision regarding 97112 for one unit of each date 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. 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. Due to the fact that the patient had the presence of a neurological insult, the neuromuscular re-education would be medically necessary but only for one unit without additional documentation. This reviewer does grant the full 45 minutes of rehabilitation for each date of service and also would allow one unit of manual therapy consisting of massage in addition to the 45 minutes of rehabilitation due to the extensive injuries that Mr. ___ sustained. The MDA gives approximately 3 months for the duration of length of disability for this type of injury, but given the multiple injuries and overlying head trauma the timeframe under review is considered still within acceptable parameters.

In regards to 97018, Medicare does not recognize prolonged use of this therapy especially in light of the fact that the patient was also receiving massage therapy, which would have similar effects for the patient. Mechanical traction is recognized by Medicare as a standard treatment with therapeutic benefits and is thus medically necessary based on the diagnosis of the patient. The combination of 97110, 97530, and 97150 would be medically necessary only up to 3 units per day according to Medicare payment policies.

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
