



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: SCD Back and Joint Clinic, Ltd 200 E 24 th Street Suite B Bryan, Texas 77803	MDR Tracking No.: M5-05-3121-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Liberty Mutual Fire Insurance Box 28	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: TWCC-60 package, explanations of benefits and CMS 1500s
 POSITION SUMMARY: Medical necessity dispute

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Explanations of benefits
 POSITION SUMMARY: None submitted

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
09-09-04 to 11-23-04	98943, 99211-25, 97012, 98940, 97150, 97110, 97112, 97124, 97530, 95851, 99212, 99213, 98941 and 97750	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$8,277.41
11-30-04, 12-14-04 and 01-13-05	99212, 9921 and 99211	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
11-15-04	A9150	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
11-01-04 and 11-3-04	G0283	<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 **prevailed** on the disputed medical necessity issues. The amount due from the carrier for the medical necessity issues equals **\$8,277.41**.

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 08-23-05, 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 dates of service 09-22-04, 09-23-04, 09-24-04, 10-08-04 and 10-11-04 and CPT code 97750-MT dates of service 09-28-04 and 10-20-04 were billed with invalid modifiers per the 2002 Medical Fee Guideline. The services will not be a part of the review.

CPT code 99080 date of service 10-21-04 and CPT code 99080-73 date of service 11-30-04 listed on the table of disputed services were paid by the carrier with check numbers 06900404 and 06900405 respectively. These services are therefore no longer in dispute and will not be a part of the review.

CPT code 95851 date of service 09-28-04 denied with denial code "D/U301" (this item was previously submitted and reviewed with notification of decision issued to payor/provider (duplicate invoice)). Since neither party submitted the original explanation of benefits this service will be reviewed per Rule 134.202. Reimbursement is recommended in the amount of \$23.15.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, Rule 134.202

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 additional reimbursement in the amount of \$8,300.56. In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee. 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:

10-06-05

Authorized Signature

Date of Findings and Decision

Order by:

10-06-05

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 29, 2005
Amended: October 5, 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: M5-05-3121-01
RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 8.30.05.
- Faxed request for provider records made on 8.31.05.
- The case was assigned to a reviewer on 9.15.05.
- The reviewer rendered a determination on 9.28.05.
- The Notice of Determination was sent on 9.29.05.

The findings of the independent review are as follows:

Questions for Review

The items in dispute: 95851 (Range of motion studies), 98940, 98941, 98943 (Chiropractic manipulation), 97150 (group therapeutic procedures), 97112 (Neuromuscular reeducation), 99211, 99211-25, 99212-25, 99213 (office visits), 97012 (mechanical traction), 97124 (massage), 97530 (therapeutic activities), 97110 (therapeutic exercise), 99080 (copies), G0283 (electrical stimulation), 97750 (physical performance test), A9150 (Biofreeze). Dates of service for review include 9.9.04 thru 1.13.05.

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 some of the disputed service(s) that occurred through the date of service 11.23.04. This includes only the CPT codes listed below:

95851	97012
98940/98941/98943	97124
97150	97530
97112	97110
99211/99211-25	97750
99212-25/99213	

The PHMO, Inc. physician reviewer has also determined to **uphold the denial** on all of the disputed service(s) that were not specifically listed above as “overturned” or that occurred after date of service 11.23.04.

Summary of Clinical History

The claimant was injured on ____, while employed with _____. After the date of injury, the claimant was given pain management, passive modalities and various forms of care. There was also early in care an attempt to return the claimant back to full time, limited duty; however, the claimant only went back part time due to availability. After time, there was a release to full time normal duty. MRI's were given to the thoracic, lumbar and right shoulder areas.

It appears that on 9.02.04 the claimant had a documented exacerbation of the right shoulder and he was taken off of work to deal with the exacerbation. The disputed dates of service start after this exacerbation.

Clinical Rationale

The treating doctor initially saw the claimant after the injury and treatment was offered. The claimant improved and returned to work. The claimant reached the point in which a release to full duty was achieved. The exacerbation that occurred was apparently a result of the return to full duty. The right shoulder in particular started to hurt again, as well as, other related areas. This occurred at the beginning of September 2004, which is right around the time that the care in question began. It is reasonable for the treating doctor to assume that if therapy worked before the exacerbation, that a second trial after the exacerbation would benefit the patient. As a result of the therapy, the claimant clearly had improvement as demonstrated by the outcome assessments on 11.23.04. There were improvements in lifting, range of motion and pain up to that point. This demonstrates that care was beneficial.

It is reasonable to state that the patient had findings on the original MRI that would be considered treatable by conservative care. It was not until well into the second course of rehab, after the exacerbation, that the patient demonstrated a reduction in improvement to constitute an orthopedic evaluation. As a result, the claimant was sent to the orthopedist and an Arthrogram was performed. The results revealed the Labral tear in the shoulder and the patient was considered a surgical candidate.

As a result, the aforementioned care was considered reasonable up until the date of 11.23.04 because the patient demonstrated improvement and was not considered surgical yet. After 11.23.04, there are no clear follow-up evaluations during the time period in question to support continued care. The orthopedist also made the clinical determination that surgery was necessary.

Therefore, approval of care thru the date of 11.23.04 that should encompass evaluations during that time period to monitor outcomes. This would include the range of motion studies, physical performance studies and office visits. These are needed to establish outcomes and they accomplished that. Active care would be considered reasonable and this would include neuromuscular reeducation and therapeutic activities. It appears that the patient also had the necessity for manual therapies such as traction, massage and manipulation. These services clearly provided a means to improvement in regards to the patient's condition based upon the outcome measurements.

The services that I do not feel were necessary would have been passive modalities such as electrical stimulation due to the chronic nature of the injury. I also do not feel that Biofreeze should be billed for as it is typically included globally with massage and soft tissue therapies. Also reimbursement for copies is likely not necessary due to this being a routine office procedure and expense of running a business.

Clinical Criteria, Utilization Guidelines or other material referenced

- *Occupational Medicine Practice Guidelines*, Second Edition.
- *The Medical Disability Advisor*, Presley Reed MD
- *A Doctors Guide to Record Keeping*, Utilization Management and Review, Gregg Fisher

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 Texas Department of Insurance /Workers Compensation division applicable to Commission Rule 102.5 this 29th day of September, 2005. The determination was amended on October 5, 2005. The TDI/WC division 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.