



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: Pain & Recovery Clinic of North Houston 6660 Airline Drive Houston, Texas 77076 | MDR Tracking No.: M5-05-3164-01 |
| | Claim No.: |
| | Injured Employee's Name: |
| Respondent's Name and Address: Employers Mutual Casualty Co. Box 19 | Date of Injury: |
| | Employer's Name: |
| | Insurance Carrier's No.: |

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60 dispute package

POSITION SUMMARY: Per the table of disputed services "All treatments and services were rendered in good faith to treat the claimant's compensable injuries".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60 package

POSITION SUMMARY: This case involves DOS 08/03/04 through 10/29/04. Carrier paid \$666.66 of a total bill of \$8,724.03 leaving \$8,057.37 in dispute according to the Requestor. Basically, the billed items were denied for improper bundling of services, e.g., bi- or tri-weekly office visits (99212), or because they exceeded the scheduled value.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

| Date(s) of Service | CPT Code(s) or Description | Medically Necessary? | Additional Amount Due (if any) |
|----------------------|---|---|--------------------------------|
| 08-03-04 to 10-29-04 | 99212, 97112 and 97140 (with the exception below) | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | \$0.00 |
| 08-03-04 to 10-29-04 | 97140 (1 unit) | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$576.30 |
| | | | |

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.

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 09-06-05, 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 97110 dates of service 09-17-04, 09-20-04, 09-22-04, 09-24-04, 09-27-04, 09-29-04, 10-01-04, 10-04-04, 10-06-04,

10-08-04, 10-11-04, 10-13-04, 10-15-04, 10-18-04, 10-20-04, 10-22-04, 10-25-04, 10-27-04 and 10-29-04 denied with denial codes "N/241/205" (Not documented/this charge was disallowed as additional information/definition is required to clarify service/supply rendered). 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 of all of the Commission requirements for proper documentation. The documentation submitted by the Requestor does not substantiate one-on-one therapy. No reimbursement is recommended.

CPT code 97140 dates of service 09-20-04, 09-22-04, 09-24-04, 09-27-04, 09-29-04, 10-01-04, 10-04-04, 10-06-04, 10-08-04, 10-11-04, 10-13-04, 10-15-04, 10-18-04, 10-20-04, 10-22-04, 10-25-04, 10-27-04 and 10-29-04 denied with denial codes "N/241/205" (Not documented/this charge was disallowed as additional information/definition is required to clarify service/supply rendered). The IRO reviewer determined that "the documentation provided for review is inadequate to support two units of 97140. The template does not describe the time spent performing manual therapy, and there is no documentation that 30 minutes was spent performing 97140". Based on the IRO determination and Rule 133.308(p)(5) no reimbursement is recommended.

CPT code 97112 on dates of service 10-18-04, 10-20-04, 10-22-04, 10-25-04, 10-27-04 and 10-29-04 denied with codes "N/241/205" (Not documented/this charge was disallowed as additional information/definition is required to clarify service/supply rendered). The IRO reviewer determined that "the DX does not support the 97112 charge, and the documentation provided for review is inadequate to document the service provided". Based on the IRO determination and Rule 133.308(p)(5) no reimbursement is recommended.

Review of CPT code 97110 date of service 08-30-04 revealed that neither party submitted an EOB. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing evidence of carrier receipt of the providers request for an EOB. No reimbursement is recommended.

CPT code 97110 dates of service 09-01-04, 09-07-04, 09-13-04 and 09-15-04 denied with denial codes "F/213" (Fee Guideline MAR reduction/the charge exceeds the scheduled value and/or parameters that would appear reasonable). 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 of all of the Commission requirements for proper documentation. The documentation submitted by the Requestor does not substantiate one-on-one therapy. No reimbursement is recommended.

CPT code 97140 dates of service 09-13-04 and 09-15-04 denied with denial codes "F/213" (Fee Guideline MAR reduction/the charge exceeds the scheduled value and/or parameters that would appear reasonable). The IRO reviewer determined that "the documentation provided for review is inadequate to support two units of 97140. The template does not describe the time spent performing manual therapy, and there is no documentation that 30 minutes was spent performing 97140". Based on the IRO determination and Rule 133.308(p)(5) no reimbursement is recommended.

CPT code 97112 dates of service 09-13-04 and 09-15-04 denied with denial codes "F/213" (Fee Guideline MAR reduction/the charge exceeds the scheduled value and/or parameters that would appear reasonable). The IRO reviewer determined that that "the DX does not support the 97112 charge, and the documentation provided for review is inadequate to document the service provided". Based on the IRO determination and Rule 133.308(p)(5) no reimbursement is recommended.

CPT code 99212 date of service 09-15-04 denied with denial codes "F/435" (Fee Guideline MAR reduction/the value of this procedure is included in the value of the comprehensive procedure). Per the 2002 Medical Fee Guideline code 99212 is not global to other services billed on date of service 09-15-04, however, the IRO reviewer determined that "Office visits would not be medically necessary at the time of physical therapy sessions". Based on the IRO decision and Rule 133.308(p)(5) no reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and Rules 133.308(p)(5) and 133.308(e)(2)(B)

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 \$576.30. The Division finds that the requestor was not the prevailing party and is not 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.

Ordered by:

12-27-05

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.

Envoy Medical Systems, LP

1726 Cricket Hollow

Austin, Texas 78758

Phone 512/248-9020

Fax 512/491-5145

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

October 21, 2005

Re: IRO Case # M5-05-3164 -01 amended 12/15/05

Texas Department of Insurance, Division of Workers' Compensation:

Envoy Medical Systems, LP (Envoy) has been certified as an independent review organization (IRO) by the Texas Department of Insurance and has been authorized to perform independent reviews of medical necessity for Division of Workers' Compensation cases. Texas HB. 2600, Rule 133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that cases be assigned to certified IROs, this case was assigned to Envoy for an independent review. Envoy has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, Envoy received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Pain Management and Anesthesiology, and who has met the requirements for the Division of Workers' Compensation Approved Doctor List or who has been granted an exception from the ADL. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and the injured employee, the injured employee's employer, the insurance carrier, the utilization review agent, any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to Envoy for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the Envoy reviewer who reviewed this case, based on the medical records provided, is as follows:

Medical Information Reviewed

1. Table of disputed services
2. Explanation of benefits
3. Requestor's position statement, C. Wheat
4. Initial medical report 4/1/04, Dr. McMillan
5. Imaging reports 4/19/04, 5/7/04
6. Initial evaluation 4/28/04, C. Meekins
7. Subsequent medical reports 2004 Dr. McMillan
8. Report 5/6/04, Dr. Jarolimek
9. Operative reports 6/14/04, 11/12/04
10. Post operative reports, Dr. Jarolimek
11. Post surgical evaluation 8/3/04, Dr. Patel
12. Daily progress notes, Pain & Recovery Clinic
13. Electrophysiology report 9/2/04
14. Report of medical evaluation 9/17/04, Dr. Leonard
15. Assessment 10/22/04, dr. Shanti
16. Physical therapy progress note 12/15/04, Dr. Taylor
17. Report of medical evaluation 2/3/05, Dr. Kantipong
18. Medical records, Dr. Murphy 2004, 2005

History

The patient injured his right shoulder in ___ when he was lifting 50-pound buckets. On 6/14/04 surgery was performed, consisting of rotator cuff repair of the right shoulder, subacromial decompression of the right shoulder and manipulation under anesthesia of the right shoulder. The patient was released by his surgeon for post-operative therapy on 7/29/04. Physical therapy treatments were inadequately documented on a template, and did not provide documentation of office visits or of neuromuscular reeducation..

Requested Service(s)

Office visits 99212 and reeducation 97112, and manual therapy 97140 8/3/04 – 10/29/04

Decision

I agree with the carrier's decision to deny the requested services except for one unit of manual therapy on each of the disputed dates.

Rationale

The records provided for this review are inadequate to support a 99212 office visit. The DX does not support the 97112 charge, and the documentation provided for review is inadequate to document the service provided. Office visits would not be medically necessary at the time of physical therapy sessions. The documentation provided for review is inadequate to support two units of 97140. The template does not describe the time spent performing manual therapy, and there is no documentation that 30 minutes was spent performing 97140. One unit of 97140 would be reasonable and necessary for post-operative therapy.

This medical necessity decision by an Independent Review Organization is deemed to be a Division of Workers' Compensation decision and order.

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 a 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 the 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 must be received by the Division of Workers' Compensation, chief Clerk of Proceedings, within then (10) days of your receipt of this decision.

Sincerely,

Daniel Y. Chin, for GP