



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.: M5-05-3172-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Employers Mutual Casualty Company 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 package, CMS 1500s and explanations of benefits

POSITION SUMMARY: "Please note that the carrier has denied reimbursement for some services based on the payment exception codes and descriptions of "Y" – "213". The charge exceeds the scheduled value and/or parameters that would appear reasonable" and "N" – "Not documented" and "205" – This charge was disallowed as additional information/definition is required to clarify service/supply rendered" and some services based on the payment exception code "U" – "244" – unnecessary medical"

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60

POSITION SUMMARY: This dispute involves various charges for physical medicine from 11-01-04-12-29-04. These procedures were not pre-authorized and begun approximately 8 months after the incident in question. These charges were denied on grounds of failure to document medical necessity and unnecessary medical treatment. Continued chiropractic care has not been documented to be of any value in this case. No further reimbursement is necessary.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
11-01-04 to 12-29-04	99212 and 97112	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00

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 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 09-02-05, 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 codes 97110 and 97140 dates of service 11-01-04, 11-03-04, 11-08-04, 11-10-04, 11-12-04, 11-15-04, 11-19-04, 11-22-04 (code 97140 only), 11-23-04, 11-24-04, 11-29-04 and dates of service 12-01-04, 12-03-04, 12-06-04, 12-08-04, 12-09-04, 12-10-04, 12-13-04, 12-15-04, 12-17-04, 12-20-04, 12-22-04, 12-23-04, 12-27-04 and 12-29-04 (code 97110 only) denied with denial codes "N/205/241" (not documented). The Requestor did not submit documentation for review. No reimbursement recommended.

CPT codes 97140 dates of service 12-01-04 (2 units), 12-03-04 (2 units), 12-06-04 (2 units), 12-08-04 (2 units), 12-09-04 (2 units), 12-10-04 (2 units), 12-13-04 (2 units), and 12-15-04 (2 units) denied with denial code "213" (charge exceeds the scheduled value and/or parameters that would appear reasonable). The carrier has made no payment. Reimbursement for code 97140 is recommended in the amount of **\$542.40 (\$67.80 billed X 8 DOS)**.

CPT code 97112 dates of service 12-01-04, 12-03-04, 12-06-04, 12-08-04, 12-09-04, 12-10-04, 12-13-04 and 12-15-04 denied with denial code "213" (charge exceeds the scheduled value and/or parameters that would appear reasonable). The carrier has made no payment. Reimbursement for code 97112 is recommended in the amount of **\$293.52 (\$36.69 billed X 8 DOS)**.

Review of CPT code 97140 (2 units) date of service 11-15-04 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the requestor submitted convincing evidence of carrier receipt of the providers request for an EOB. Reimbursement is recommended in the amount billed of **\$67.80**.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, Rules 134.202(d) and 133.307(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 \$903.72. 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:

11-04-05

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.

October 24, 2005
Amended November 3, 2005

ATTN: Program Administrator
Texas Department of Insurance/Workers Compensation Division
7551 Metro Center Drive, Suite 100
Austin, TX 78744
Delivered by fax: 512.804.4868

Notice of Determination

MDR TRACKING NUMBER: M5-05-3172-01
RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 9.2.05.
- Faxed request for provider records made on 9.6.05.
- TDI/DWC issued an Order for payment on 9.21.05.
- The case was assigned to a reviewer on 10.5.05.
- The reviewer rendered a determination on 10.21.05.
- The Notice of Determination was sent on 10.24.05.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of CPT codes 99212-office visits and 97112-reeducation
"FEE" denied items were not reviewed. Dates of service in dispute: 11.1.04-12.29.04

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 **uphold the denial** on the requested service(s).

Summary of Clinical History

Mr. ____ was injured as a brick layer lifting heavy, 50-pound buckets of concrete and pouring them into holes on top of a wall when he injured his shoulder and neck musculature. He had an evaluation and workup and ultimately had surgical repair for a rotator cuff injury and then went on to develop adhesive capsulitis and frozen shoulder and underwent manipulation under anesthesia. Post that, he was initiated to this particular round of therapy. He was also evaluated by Dr. Murphy, a neurosurgeon, who felt that he had multiple levels of cervical-brachial nerve injury that were non-surgical in nature.

He also had a DD evaluation, who felt that he had not reached MMI during the same time, and needed additional aggressive and extensive therapy.

Clinical Rationale

In reviewing these records, while there is excellent description of all of these codes, their application and use in different situations, and the extensive history with the provider regarding the patient, I have to conclude that there is no question that the therapy is reasonable and necessary in terms of therapeutic treatment that should have occurred between the dates of 11.01.04 and 12.29.04.

Having said that, the physician codes of 99212, with the reasons provided in order to make sure the patient was safe to participate in therapy on these dates, required a physician evaluation is, in my opinion, inconsistent with the practice of medicine in the state of Texas and inconsistent in treating individuals with brachial plexus and stress injuries and rotator cuff injuries who are status post manipulation under anesthesia.

Having treated and had experience with management of many of these patients, it does not require a physician to evaluate these patients on every visit. This is the role of the licensed person providing the therapy. It does not take two licensed individuals to determine the safety of these procedures, nor is there any particular concern of any deleterious effect of an individual receiving strengthening or stretching exercises after manipulation under anesthesia. Therefore, I see no clinical basis for practitioner codes of 99212 for the reasons stated by the provider.

This individual required one-on-one therapy on a continued basis to maximize the benefits of the surgical repair and subsequent manipulation under anesthesia of the shoulder range of motion. The codes for neuromuscular re-education of 97112 are typically used after neurologic injuries such as a stroke for re-education and typically cannot really be divided out as being necessary and distinctly different than the one-on-one codes of 97110, which were provided as well. I see no specific clinical indication for both of these to have been provided on each visit on an ongoing basis for this patient. In particular, neuromuscular re-education does not typically have a role in treatment of an individual with rotator cuff tear and in a postoperative rehab program/myofascial pain, certainly not in addition to the same individual providing one-on-one care and education and strengthening in the same session. Therefore, based on generally accepted principles of billing and therapeutic treatment for individuals with similar injuries in the state of Texas, this does not appear to be warranted or necessary.

Clinical Criteria, Utilization Guidelines or other material referenced

This conclusion is supported by the reviewers' clinical experience with over 10 years of patient care.

The reviewer for this case is a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical medicine and Rehabilitation, and is engaged in the full time practice of medicine.

The review was performed in accordance with Texas Insurance Code 21.58C and the rules of Texas Department of Insurance /Division of Workers' Compensation. In accordance with the act and the rules, the review is listed on the DWC'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, the injured employee, injured employee's insurance carrier, the URA or any 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 /Division of Workers Compensation applicable to Commission Rule 102.5 this 24th day of October, 2005. The Division of Workers Compensation will forward the determination to all parties involved in the case including the requestor, respondent and the injured worker.

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.