



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.:

M5-05-3177-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:

Old Republic Insurance Company

Box 02

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60 package, explanations of benefits and CMS 1500s

POSITION SUMMARY: From the table of disputed services "All treatments & services were provided in good faith to treat the injured employee's compensable injuries and their sequelae".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60

POSITION SUMMARY: This is a fee dispute involving retrospective medical necessity. The carrier disputes that the provider has shown that the treatment underlying the charges was medically reasonable and necessary. Further, the carrier challenges whether the charges are consistent with applicable fee guidelines. The carrier asserts that it has paid according to applicable fee guidelines. All reductions of the disputed charges were appropriately made. Further, the documentation provided does not establish medical necessity.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
11-30-04 to 02-14-05	99212, 97110, 97140 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 09-20-05, 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.

Review of CPT code 99212 dates of service 01-17-05, 01-18-05, 01-21-05, 01-24-05, 01-26-05, 01-28-05 and 02-14-05 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for EOBs. Reimbursement is recommended in the amount of **\$345.87 (\$49.41 X 7 DOS)**.

Review of CPT code 97110 dates of service 01-17-05, 01-18-05, 01-24-05, 01-26-05 and 02-14-05 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for EOBs. 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". The Requestor did not submit documentation for review. 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. No reimbursement is recommended.

Review of CPT code 97140 dates of service 01-17-05 (2 units), 01-18-05 (2 units), 01-21-05 (2 units), 01-24-05 (2 units), 01-26-05 (2 units), 01-28-05 (2 units) and 02-14-05 (2 units) revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for EOBs. Reimbursement is recommended in the amount of **\$475.16 (\$33.94 X 14 DOS)**.

Review of CPT code 97112 dates of service 01-17-05, 01-18-05, 01-21-05, 01-24-05, 01-26-05 and 02-14-05 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for EOBs. Reimbursement is recommended in the amount of **\$226.68 (\$37.78 X 6 DOS)**.

Review of CPT code 97032 date of service 01-21-05 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for an EOB. Reimbursement is recommended in the amount of **\$20.34**.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.202(c)(1) 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 reimbursement in the amount of \$1,068.05. 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. The Division finds that the requestor was not the prevailing party and is not entitled to a refund of the IRO fee.

Ordered by:

11-17-05

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.

November 7, 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: M5-05-3177-01
RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 9.20.05.
- Faxed request for provider records made on 9.21.05.
- TDI/DWC issued an Order for Payment on 10.04.05.
- The case was assigned to a reviewer on 10.14.05.
- The reviewer rendered a determination on 11.03.05.
- The Notice of Determination was sent on 11.07.05.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of 99212-OV, 97110-Therapeutic exercises, 97140-manual therapy tech, 97112-neurologic reeducation
Dates of service for review: 11.30.04-2.14.05 Items denied for "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 **uphold the denial** on the requested service(s).

Summary of Clinical History

Extensive case records provided regarding claimant Mr. _____. He reports occupational injury occurred _____, while employed with _____, working as a laborer. He injured his low back carrying, lifting heavy wood materials. He reported injury and continued working. He sought medical attention. He had diagnostics including MRI of the lumbar spine showing disc bulges, as well as, anterior wedge of T12 vertebral body felt to be from the previous old trauma. There was some evidence of some mild facet arthropathy. Electrodiagnostic studies were performed in January 2004, showing abnormal dermatosensory evoked potentials. No documented needle EMG findings were noted. Concern and suspicions raised for radiculopathy without confirmation with needle EMG examination. The patient received an extensive physical therapy program for, what has essentially amounted to, severe low back pain, lumbar sprain and strain, and lumbar degenerative disc disease. There are no findings to suggest evidence of radiculopathy; although, there may be some radicular irritation. The patient went on to receive extensive care at Pain Recovery Clinic of North Houston. The billing codes for those visits have been reviewed. These codes applied to different services including medical office visits 99212 provided three times a week by provider, therapeutic exercises 97110 provided three times a week, and manual therapy 97140 provided three times a week, and neurologic reeducation 97112 provided three times a week.

Clinical Rationale

The dates of services and three codes were denied based on the fact they were excessive, duplicative, medically unnecessary, and medically not warranted; based on the fact this individual had musculoskeletal sprain strain injury with radicular nerve irritation and had been injured on ____, and services were provided November 2004. The services provided were those of a basic physical therapy program that the individual already received previously. The extent of the services provided is beyond what is reasonably necessary for the region. The charge for physician visits is medically unnecessary, unwarranted, and quite overdone in this case. Typically a physician will see a patient every two weeks while participating in a three time week physical therapy program for chronic lumbar sprain/strain, soft tissue injury with conservative radiculitis. There was never any indication for three times a week. There is no indication for neurologic reeducation on this type of procedure 97112 as typically utilized in those receiving stroke or spinal cord rehabilitation and has no drug benefit in a muscular sprain/strain where the goal of treatment is elongation of the spastic muscles and then strengthening. The provision of manual therapy can be effective in treating acute myofascial and current myofascial pain, but achieves along with therapeutic exercises in individuals that have been injured some one year before. It is not warranted necessary in this individual's case and it seems the majority of the treatments provided were excessive, inconsistent with norms of the region, medically unwarranted, and not necessary.

Clinical Criteria, Utilization Guidelines or other material referenced

- *Occupational Medicine Practice Guidelines, Second Edition.*
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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 the treating and/or referring provider, the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO.

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, and 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 7th day of November 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.