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.: M5-05-3217-01
Killeen Rehab Group 5445 La Sierra Drive # 204 Dallas, TX 75231	Claim No.: Injured Employee's Name:
Respondent's Name and Address: TX Mutual Insurance Company, Box 54	Date of Injury: Employer's Name: Insurance Carrier's No.:

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 as indicated on the Table of Disputed Services states, "The insurance carrier has reduced the payment of this patient's claims. The MAR was not paid. The treatments were medically necessary and his recovery would have been negatively impacted without these services."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary states, "The requestor billed both CPT codes 98940 and 97140. 97140 is bundled to 98940. The requestor billed timed codes exceeding 45 minutes."

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)
10-6-04 – 4-12-05	CPT codes 99212, 97110, 97112, 97032, 97750, 97124	☐ Yes ☒ No	0

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 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 9-9-05 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.

The carrier denied CPT code 97124 on 10-4-04, 10-6-04, 10-15-04, 10-25-04, 11-8-04, 11-10-04, 11-15-04, 11-17-04, 12-15-04, 12-29-04, 1-10-05 and 1-31-05 with "435 - the value of the procedure is included in the value of the comprehensive procedure."

According to the 2002 MFG this procedure is considered by Medicare to be a component procedure of CPT code 98940. Recommend no reimbursement.

The carrier denied CPT code 97112 on 10-6-04, 10-15-04, 10-25-04, 11-8-04, 11-10-04, 11-15-04 and 11-17-04 with "435 - the value of the procedure is included in the value of the comprehensive procedure." According to the 2002 MFG this procedure is considered by Medicare to be a component procedure of CPT code 98940. Recommend no reimbursement.

Regarding CPT code 99080-73 on 10-4-04: The carrier denied this service with a "284 - No allowance was recommended as this procedure indicates a Status 'B'". The TWCC-73 is a required report per Rule 129.5. Recommend reimbursement of $15.00.

CPT cod 97112 for date of service 10-11-04 was billed by the requestor. Neither party submitted EOB's for these dates of services (and did not timely respond to the request for additional information). There is convincing evidence of carrier receipt of the provider's request for EOB's in accordance with Rule 133.307(e)(2)(B). Recommend reimbursement of $35.93.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 129.5 and 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 Division has determined that the requestor is entitled to reimbursement in the amount of $50.93. The requestor 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.

Findings and Decision and Order by:

		10-18-05
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.

TEXAS WORKERS COMP. COMISSION
AUSTIN, TX 78744-1609

CLAIMANT: ___.
EMPLOYEE: ___.
POLICY: M5-05-3217-01
CLIENT TRACKING NUMBER: M5-05-3217-01/5278

Medical Review Institute of America (MRIoA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Workers Compensation Commission has assigned the above mentioned case to MRIoA for independent review in accordance with TWCC Rule 133 which provides for medical dispute resolution by an IRO.

MRIoA has performed an independent review of the case in question 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. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the TWCC approved doctor list (ADL). The reviewer has signed a statement indicating they have no known conflicts of interest existing between themselves and the treating doctors/providers for the patient in question or any of the doctors/providers who reviewed the case prior to the referral to MRIoA for independent review.

Records Received:
Records Received from State:
Notification of IRO assignment – 2 pages
Medical Dispute Resolution Request/Response form – 3 pages
Provider listing – 1 page
Table of disputed charges – 3 pages
EOBs – 16 pages

Records Received from Requestor:
Notification of IRO assignment – 3 pages
Medical Dispute Resolution Request/Response form – 1 page
Summary of Requestor's Position Regarding This Fee Dispute – 1 page
Table of disputed charges – 3 pages
EOBs – 53 pages
HCFAs – 27 pages
EOB letter – 1 page
Fax cover sheet – 1 page
CT report – 2 pages
Subsequent Medical Narrative Report – 24 pages
Rehab assessment – 2 pages
Daily notes – 52 pages
Texas Workers' Compensation Work Status report – 4 pages
PPE report – 8 pages

Summary of Treatment/Case History:
The claimant underwent physical medicine treatments after sustaining injury at work on ___.

Questions for Review:
Were the physical medicine treatments from 10/06/04 through 04/12/05 (not marked as "fee" items) medically necessary to treat this patient's injury?

Explanation of Findings:
Were the physical medicine treatments from 10/06/04 through 04/12/05 (not marked as "fee" items) medically necessary to treat this patient's injury?

No treatment records were available for review during the time period immediately preceding the treatment in question. Therefore, it is unknown what kinds of therapies and/or treatments had been attempted, what was beneficial and what was not, and were the disputed treatments different or more of the same? Without medical treatment records that answer those questions, there is less than sufficient documentation to support the medical necessity of the disputed treatment.

Physical medicine is an accepted part of a rehabilitation program following an injury. However, for medical necessity to be established, there must be an expectation of recovery or improvement within a reasonable and generally predictable time period. In addition, the frequency, type and duration of services must be reasonable and consistent with the standards of the health care community. General expectations include:

A. As time progresses, there should be an increase in the active regimen of care, a decrease in the passive regimen of care and a decline in the frequency of care.
B. Home care programs should be initiated near the beginning of care, include ongoing assessments of compliance and result in fading treatment frequency.
C. Patients should be formally assessed and re-assessed periodically to see if the patient is moving in a positive direction in order for the treatment to continue.
D. Supporting documentation for additional treatment must be furnished when exceptional factors or extenuating circumstances are present.
E. Evidence of objective functional improvement is essential to establish reasonableness and medical necessity of treatment. Expectation of improvement in a patient's condition should be established based on success of treatment. Continued treatment is expected to improve the patient's condition and initiate restoration of function. If treatment does not produce the expected positive results, it is not reasonable to continue that course of treatment.

In this case, there is no documentation of objective or functional improvement or that the treatment fulfilled statutory requirements since the claimant did not obtain relief, promotion of recovery was not accomplished and there was no enhancement of the employee's ability to return to or retain employment. Specifically, the patient's pain ratings actually increased and some ranges of motion decreased from 08/26/04 to 11/18/04. The slight range of motion gains obtained during the disputed time period would have likely been achieved through performance of a home program.

Conclusion/Decision to Not Certify:
Treatment is not medically necessary.

References Used in Support of Decision:

1. Haldeman, S; Chapman-Smith, D; Petersen, D Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen Publishers, Inc.
2. ACOEM Occupational Medicine Practice Guidelines: Evaluation and Management of Common Health Problems and Functional Recovery in Workers, 2nd Edition.
3. Centers for Medicare and Medicaid Services, Carriers Manual Part 3 Chapter II - Coverage and Limitations Rev. 1606 / Page 2-94.11
4. Texas Labor Code 408.021

This review was provided by a chiropractor who is licensed in Texas, certified by the National Board of Chiropractic Examiners, is a member of the American Chiropractic Association and has several years of licensing board experience. This reviewer has written numerous publications and given several presentations with their field of specialty. This reviewer has been in continuous active practice for over twenty-five years.

MRIoA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the treating provider, payer and/or URA, patient and the TWCC.

It is the policy of Medical Review Institute of America to keep the names of its reviewing physicians confidential. Accordingly, the identity of the reviewing physician will only be released as required by state or federal regulations. If release of the review to a third party, including an insured and/or provider, is necessary, all applicable state and federal regulations must be followed.

Medical Review Institute of America retains qualified independent physician reviewers and clinical advisors who perform peer case reviews as requested by MRIoA clients. These physician reviewers and clinical advisors are independent contractors who are credentialed in accordance with their particular specialties, the standards of the American Accreditation Health Care Commission (URAC), and/or other state and federal regulatory requirements.

The written opinions provided by MRIoA represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to MRIoA for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Medical Review Institute of America assumes no liability for the opinions of its contracted physicians and/or clinician advisors. The health plan, organization or other party authorizing this case review agrees to hold MRIoA harmless for any and all claims which may arise as a result of this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

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