



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.: M5-05-3220-01
SCD Back and Joint Clinic, Ltd. 200 E. 24 th Street, Suite B Bryan, Texas 77803	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:
Texas Mutual Insurance Company, Box 54	

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 states, "The carrier denied payment for certain medical services provided to the patient. It is our position that these services were reasonable, necessary, and related to the compensable injury. Appeals and follow up with the carrier have failed to resolve the dispute."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included TWCC 60 form and some Explanations of Benefits. Position summary states, "The Clinic billed timed codes exceeding 45 minutes. Texas Mutual based its action on LCD Y-13B-R7."

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)
11-2-04 – 3-30-05	CPT codes 97750, 97150, 97110, 97530, 97112, 99211-25, 99212, G0283, 98940, 98943, 97124, A9150, 97026	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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.

CPT code 99211 on 9-21-04 was denied by the carrier as "858 – Physical Medicine and Rehab Services may not be reported in conjunction with an E/M code performed on the same day." Per the 2002 MFG that this service is not global to another service billed on this date. Reimbursement of \$23.35 is recommended.

CPT code 99212 on 9-22-04 was denied by the carrier as "858 – Physical Medicine and Rehab Services may not be reported in conjunction with an E/M code performed on the same day. Per the 2002 MFG this service is not global to another service billed on this date. Reimbursement of \$41.91 is recommended.

CPT code 97112 on 10-15-04 was denied by the carrier as "435-The value of this procedure is included in the value of the comprehensive procedure." 97112 is considered by Medicare to be a component procedure of 98940 and 97150 which were billed on this date of service. Recommend no reimbursement.

CPT code 97124 on 10-15-04, 10-18-04, 10-20-04 was denied by the carrier as "435-The value of this procedure is included in the value of the comprehensive procedure." 97124 is considered by Medicare to be a component procedure of 98940 and 97150 which were billed on this date of service. Recommend no reimbursement.

CPT code 97530 on 10-15-04, 10-18-04, 10-20-04 was denied by the carrier as "434-The value of this procedure is included in the value of the mutually exclusive procedure." 97530 is considered by Medicare to be a mutually exclusive procedure of 97150 which was billed on this date of service. Recommend no reimbursement.

CPT code 97112 on 10-18-05 and 10-20-04 was denied by the carrier as "434-The value of this procedure is included in the value of the mutually exclusive procedure." 97112 is considered by Medicare to be a mutually exclusive procedure of 98940 and 97150 which were billed on this date of service. Recommend no reimbursement.

Rule 134.202 (b) states that Texas Workers' Compensation system participants shall apply the Medicare program reimbursement coding, billing, and reporting payment policies in effect on the date a service is provided. Rule 133.1(a)(3)(C) states that a complete medical bill includes correct billing codes from Commission fee guidelines in effect on the date of service. The requestor billed codes 97139-EU and 97750-MT for dates of service from 10-15-04 – 10-28-04. These modifiers are invalid with these codes after 8-1-03; therefore, no review and no reimbursement recommended. The requestor will be billed for using invalid modifiers.

Regarding CPT code 99212 on 2-1-05 and 2-3-05: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). Recommend reimbursement of \$83.82.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.307, 133.308 and Rule 134.202(c)(1).

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 not entitled to a refund of the paid IRO fee. The Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute in the amount of \$149.08. 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:

Authorized Signature

Typed Name

11-15-05

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.

NOTICE OF INDEPENDENT REVIEW DECISION

October 13, 2005

Amended Letter: November 9, 2005

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking # : M5-05-3220-1
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and the 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. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient sustained a work-related injury on ___ when he was lifting iron and began to experience low back pain. The patient had been treated with chiropractic therapy, medications, and surgery.

Requested Service(s)

Dynatron Human performance test/Delorme muscle testing, group therapeutic procedures, therapeutic exercise, therapeutic activities, neuromuscular re-education, office visits, electrical stimulation, chiropractic manipulation treatment, massage therapy, Biofreeze – Durable Medical Equipment, and infrared therapy, all from 11/02/2004 through 03/30/2005.

Decision

It is determined that the Dynatron Human performance test/Delorme muscle testing, group therapeutic procedures, therapeutic exercise, therapeutic activities, neuromuscular re-education, office visits, electrical stimulation, chiropractic manipulation treatment, massage therapy, Biofreeze – Durable Medical Equipment, and infrared therapy, all provided from 11/02/2004 through 03/30/2005, were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

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) Home care programs should be initiated near the beginning of care, include ongoing assessments of compliance and result in fading treatment frequency. (B) 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. (C) Supporting documentation for additional treatment must be furnished when exceptional factors or extenuating circumstances are present. (D) 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 in this patient's condition and no evidence of a change of treatment plan to justify additional treatment in the absence of positive response to prior treatment. Moreover, the disputed services failed to fulfill statutory requirements for medical necessity since the patient obtained no relief, promotion of recovery was not accomplished, and there was no enhancement of the employee's ability to return to or retain employment. While the provider claimed "remarkable VAS pain scale improvement" from 09/21/2004 through 03/03/2005, this is not the case since the patient's pain rating was 3/10 on 09/21/2004 and 4/10 on 03/30/05

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment

Information Submitted to TMF for TWCC Review

Patient Name:

TWCC ID #: M5-05-3220-1

Information Submitted by Requestor:

- Letter from The Back & Joint Clinic dated 9-13-2005
- Medical Narrative Report
- Claims
- Muscle Strength Testing
- Treatment plan
- Treatment notes
- Office visit reports
- Letters for Doctor Wyatt
- Operative reports
- Radiological reports
- BJD Submission to IRO

Information Submitted by Respondent:

- Letter to TMF for Texas Mutual
- Discharge summary from Providence Health Center
- Patient office visit notes
- Designated Doctor Report