



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.: M5-05-3269-01
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:
Liberty Mutual Fire Insurance, Box 28	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include DWC 60 form, Explanations of Benefits, medical documentation and CMS 1500's. Position summary states, "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

No response or position summary was received.

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)
9-23-04	CPT codes 99213	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$58.99
9-24-04	CPT code 95851	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$23.15
9-17-04 - 9-24-04	CPT code 98940	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$120.52
9-25-04 - 12-16-04	CPT codes 99213, 95851, 98940	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
9-17-04 - 12-16-04	CPT codes 99211, 99212, 97012, 98943, 97024, 97112, 97124, 97018, 97530, 97150	<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 majority of the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$202.66.

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 code 97139-EU for dates of service from 9-17-04 through 12-16-04. These modifiers are invalid with these codes after 8-1-03; therefore, no review and no reimbursement recommended.

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 9-13-05 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.

Regarding CPT code 99080-73 on 9-28-04: The carrier denied this service with a "V" for unnecessary medical treatment based on a peer review; however, the TWCC-73 is a required report per Rule 129.5 and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter; Recommend reimbursement of \$15.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, Rule 129.5 and Rule 134.202.

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 \$217.66. 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.

November 11, 2005

October 11, 2005

TDI, Division of Workers' Compensation
Medical Dispute Resolution
Fax: (512) 804-4868

MDR #: M5-05-3269-01
DWC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: IRO 5055

Dear Ms. ____:

IRI has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc. and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and 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 Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in chiropractic, and is currently on the DWC Approved Doctor List.

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.

Sincerely,

Gilbert Prud'homme
General Counsel
GP:dd

REVIEWER'S REPORT
M5-05-3269-01

Information Provided for Review:

DWC-60, Table of Disputed Services, EOB's

Information provided by Requestor:

Correspondence

Office Notes 04/23/04 – 09/23/04

Daily Progress Notes 04/23/04 – 12/16/04

PT Notes 04/23/04 – 10/07/04

Range of Motion 05/11/04 – 09/24/04

Radiology Reports 06/01/04 – 06/03/04

Information provided by Respondent:

Designated Reviews

Pain Management:

Office Notes 04/29/04 – 05/26/04

Neurology:

Office Visit 06/10/04

Psychologist:

Office Visit 10/26/04

Clinical History:

Patient is a 41-year-old female bone cutter for a chicken processing plant who approximately one month prior, began noticing pain in her upper extremities. She initially reported this to her company nurse, but continued working through the pain. When it continued to worsen, she filed an injury report citing ___ as the onset date. She had been working for the plant for four and one-half years, processing approximately 40 chickens per minute, eight hours per day, five to six days per week, when this occurred. She was also reportedly suspended from her job on 4/22/04 due to inability to perform her work.

She presented to a doctor of chiropractic who began conservative chiropractic care, physical therapy and rehabilitation.

Disputed Services:

Established patient office visits, levels I, II and III (99211, 99211-25, 99212, 99212-25, & 99213), mechanical traction (97012), chiropractic manipulative therapies, spinal 1-2 areas (98940), extraspinal manipulative therapies (98943), diathermy (97024), massage (97124), neuromuscular reeducation (97112), paraffin baths (97018), therapeutic activities (97530), thoracic range of motion testing (95851), and group therapeutic exercises (97150) for dates of service 9/17/04 through 12/16/04.

Decision:

The reviewer partially agrees with the determination of the insurance carrier in this case, as follows:

The level III established patient office visit (99213) on 9/23/04, the thoracic range of motion test on 9/24/04 (**95851**), and the chiropractic manipulative therapies, spinal 1-2 areas (98940) *from 9/17/04 through 9/24/04 only*, are approved. All remaining services and procedures, *including the chiropractic manipulative therapies, spinal 1-2 areas, after 9/24/04 and all remaining office visits*, are denied.

Rationale:

The last full examination submitted for review in this case *prior to* the dates of service in dispute was 7/8/04. The only reexamination provided *during* the dates of service in dispute was on 9/23/04 (with an additional thoracic range of motion evaluation reported one day later on 9/24/04). So the only other medical records available to document patient status were the computer-generated daily notes submitted for the dates of service in dispute. Since the thoracic range of motion performed on 9/24/04 revealed that the range of motion improved from the 7/8/04 testing, the chiropractic spinal manipulations (98940) performed up until that time were approved. But since no additional thoracic range of motion values were submitted after that date, and since the records demonstrated that neither the patient's symptoms nor her work status improved, spinal manipulations beyond that date were not supported as medically necessary (pain scale ratings on 9/17/04

were recorded at a “6” out of a possible “10,” and were still at a “6” on 12/16/04).

Insofar as the remainder of treatments and procedures directed to the patient’s bilateral upper extremities and neck were concerned, according to the examination of 7/3/04, the records indicated that the carpal tunnel compression testing (utilizing 15 psi) yielded 22 seconds on the right and 22 seconds on the left. But on the reexamination of 9/23/04, repeat carpal tunnel compression testing (again with 15 psi) had worsened to only 15 seconds on the right and 20 seconds on the left. Furthermore, in terms of grip strength testing, the records between the two same dates revealed that the right-sided grip strength *worsened*. In fact, the actual examination report stated, “Right grip strength has significantly decreased since testing on 07/08/2004.” Therefore, the care rendered failed to meet the statutory requirements¹ for medical necessity because the patient did not obtain relief, promotion of recovery was documented as having been accomplished, and there was no enhancement of the employee’s ability to return to employment.

¹ Texas Labor Code 408.021