



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

<b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address:	MDR Tracking No.: M5-05-3310-01
Brad Burdin, D. C. 9502 Computer Dr. Suite 100 San Antonio, TX 78229	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
American Home Assurance, Box 19	Employer's Name:
	Insurance Carrier's No.:

#### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included DWC 60 form, Explanations of Benefits and CMS 1500's. Position summary states, "Treatments and therapies were consistent and within the scope of chiropractic practice. Documents are being presented to substantiate health care provided to relieve the effects of the compensable injury."

#### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No position summary or documentation 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)
9-16-04 – 11-8-04	CPT Code 99213	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$61.89
9-16-04 – 11-8-04	CPT code 97140 (\$31.73 X 3 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$95.19
9-16-04 – 11-8-04	CPT code 97035 (\$14.81 X 5 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$74.05
9-16-04 – 11-8-04	CPT code G0283 (\$13.41 X 5 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$67.05

#### 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 prevail on the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$298.18.

Based on review of the disputed issues within the request, the 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 9-22-05 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 99214 on 9-21-04 and 10-05-04 was denied by the carrier as "U454 – this office visit is included in the value of the surgery or anesthesia procedure.) Per the 2002 MFG this service is not global to any other service performed on this date. Recommend reimbursement of \$193.82.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. 133.308 and 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 IRO fee. The requestor is entitled to reimbursement for services in the amount of \$492.00. 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:

		11-14-05
_____ 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.**

September 30, 2005

TX DEPT OF INS DIV OF WC  
AUSTIN, TX 78744-1609

CLAIMANT: \_\_\_\_

EMPLOYEE: \_\_\_\_

POLICY: M5-05-3310-01

CLIENT TRACKING NUMBER: M5-05-3310-01/5278

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### AMENDED DECISION 11/10/05

Medical Review Institute of America (MRIoA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Department of Insurance Division of Workers' Compensation has assigned the above mentioned case to MRIoA for independent review in accordance with DWC 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 DWC approved doctor list (ADL). The reviewing provider has no known conflicts of interest between that provider 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 IRO.

#### Records Received:

Records from state:

- Notification of IRO Assignment, Table of Disputed Services, Carrier EOBs

Records from requestor:

- Letter to MRIoA from treating provider's office (Brad Burdin, DC), 9/21/05
- Letter to Dr. Burdin from DWC, 9/21/05
- Table of records sent, 9/21/05
- Initial office visit, Dr. Burdin, 8/8/00
- Office visits, Dr. Burdin, 9/23/03-8/10/05
- DWC 73, Dr. Burdin, 9/23/03-8/10/05
- Daily Treatment Logs, 3/8/04-9/15/05
- Office notes, Mark Dedmon, PA, 3/2/04-9/15/05
- Office notes, David Hirsch, DO, 9/12/03-10/8/03
- Office notes, Morris Lampert, MD, 11/2/04
- Rx, Dr. Lampert, 11/2/04, 3/2/04
- RME report, Patrick Mulroy, MD, 6/29/05
- Preauthorization request, Dr. Burdin, 8/19/05

#### Summary of Treatment/Case History:

Patient is a 52-year-old senior records clerk for the past 23 years for a major \_\_\_\_\_ company who, on \_\_\_\_, began experiencing left elbow and wrist pain.

#### Questions for Review:

1. Were the established patient office visits, levels II, III and IV (#99212, #99213 & #99214, respectively), manual therapy technique (#97140), ultrasound (#97035), electrical stimulation, unattended (#G0283), and durable medical equipment (#E1399) from 9/16/04 through 11/8/04 medically necessary to treat this patient's injury?

#### Explanation of Findings:

The ultrasound (#97035), electrical stimulation, unattended (#G0283), the manual therapy technique (#97140), and the established patient office visit, level III (#99213) performed on 9/16/04 only, are medically necessary. All remaining established patient office visits, levels III (#99213), other than the one performed on 9/16/04, as well as all established patient office visits, levels II and IV (#99212 & #99214) and the durable medical equipment (#E1399), are not medically necessary.

Rationale: In this case, the medical records submitted documented that the patient experienced a flare-up from her \_\_\_\_ injury on/around 9/2/04, and sought treatment. Since she had not seen the treating doctor for several months, it was medically necessary and appropriate for the doctor

to perform an Evaluation and Management service to assess her condition. Therefore, the level III established patient office visit (#99213) performed on 9/16/04 was approved.

Thereafter, the records demonstrated that the treatment rendered relieved the patient's symptoms (initial Visual Analog Scale was recorded at "8 out of as possible 10" on date of service 9/22/04, and "0 out of a possible 10" on 11/8/04), and kept her at work (DWC-73 dated 9/16/04 returned the patient to work without restrictions). In addition, these post-injection services were specifically ordered by the health care provider who performed the injections, who wrote in his prescriptive plan, "Recommend 6 episodes of e-stim, ultrasound, and soft tissue mobilization to the L trapezius region." Therefore, these disputed services fulfilled the statutory requirements (1) for medical necessity since the patient obtained relief, promotion of recovery was accomplished and there was an enhancement of the employee's ability to retain her employment.

However, insofar as the various other established patient office visits, levels II and III (#99212 & #99213) were concerned, the medical necessity for performing additional Evaluation and Management services on a routine, visit-to-visit basis was not supported, particularly not when a treatment plan was already established by the referring health care provider/P.A. Moreover, the single level IV established patient office visit for review during the dates of service in dispute (performed on 10/26/04) was not supported as medically necessary since the records reflected that a detailed office visit had just been performed and reported on 10/5/04. Also, according to the records, nothing had materially changed with regard to the patient status that would otherwise warrant the performance of another high-level Evaluation and Management service so soon after the previous one.

**Conclusion:**

Decision to Certify:

The ultrasound (#97035), electrical stimulation, unattended (#G0283), the manual therapy technique (#97140), and the established patient office visit, level III (#99213) *performed on 9/16/04 only*, are medically necessary.

Decision to Not Certify:

All remaining established patient office visits, levels III (#99213), *other than the one performed on 9/16/04*, as well as all established patient office visits, levels II and IV (#99212 & #99214) and the durable medical equipment (#E1399), are not medically necessary.

**References Used in Support of Decision:**

1. Texas Labor Code 408.021

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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 given numerous presentations with their field of specialty. This reviewer has been in continuous active practice for over twenty 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, payor and/or URA, patient and the DWC.

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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