



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.: M5-05-3313-01
Richard Stephenson, D. C. 322 North Main St. Bryan, TX 77803	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  Box 45	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 and CMS 1500's. Position summary states, "This care, as evidenced by my documentation, satisfies without limit the bases of medical necessity as set forth in Texas Labor Code, Section 408.021(a) and further complies with the legal responsibilities of Treating Doctors/providers rendering care under the Texas Workers' Compensation System."

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

Documents included TWCC 60 form. Position summary states (Table of Disputed Services), "The office will maintain its denial of CPT codes 99213 and 97018."

#### 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)
12-13-04 – 1-3-05	CPT code 99213 (\$50.00 X 9 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$450.00

#### 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 prevail on the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$450.00.

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.

CPT code 97018 from 12-21-04 through 1-3-05 was denied by the carrier as "G-Unbundling." Per the 2002 MFG, Paraffin Bath is not global to any other service billed on this date. Recommend reimbursement according to 28 Texas Administrative Code Sec. 134.202(c)(1) of \$54.67 (\$7.81 X 7 DOS).

**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 carrier must refund the amount of the IRO fee(\$460.00) to the requestor within 30 days of receipt of this order. The Division has determined that the requestor is entitled to reimbursement in the amount of \$504.67. 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

11-07-05

\_\_\_\_\_  
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.**

October 18, 2005

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

Re: Medical Dispute Resolution  
MDR #: M5-05-3313-01  
TWCC#:  
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 licensed 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 M5-05-3313-01**

**Information Provided for Review:**  
DWC-60, Table of Disputed Services, EOB's  
Information provided by Requestor:  
Office Notes 12/10/04 – 08/01/05

PT Notes 12/13/04 – 07/29/05  
Nerve Conduction Study 07/14/05  
Radiology 12/22/04

**Physical Medicine:**

Office Visit 12/30/04

**Spine:**

Office Visit 01/12/05

**Family Practice:**

Office Notes 12/16/04 – 02/24/05

**Pain Management:**

Office Notes 02/22/05 – 06/23/05  
OR Report 04/11/05

**Clinical History:**

The records indicate the patient was injured on the job on \_\_\_ while restraining a juvenile. The juvenile had her arm in a compromised position during the restraint. The juvenile kept jerking her arm and she eventually fell on the floor, landing on her neck and left wrist. The patient felt immediate pain in the neck and left wrist. Her pain increased over the next day and included severe neck pain with radiation down the left arm and left wrist with swelling and weakness of the left hand. Due to the increase in her pain levels and restrictions, she sought appropriate treatment.

**Disputed Services:**

Office visits 99213 on 12/13/04 through 01/03/05.

**Decision:**

The reviewer disagrees with the determination of the insurance carrier and is of the opinion the services in dispute as stated above were medically necessary in this case.

**Rationale:**

As mentioned above, the patient was initially injured on the job on \_\_\_\_. She sought appropriate medical care, and on 12/10/04 there was an evaluation that revealed significant positive subjective and objective findings to warrant initiation of a treatment plan. Appropriate radiographic examination was performed. Treatment program 3 times a week for 4 weeks utilizing chiropractic manipulation and passive physical therapy modalities was begun. Over the course of treatment, appropriate diagnostic testing in the form of MRI scan and nerve conduction studies was performed. Additional referral for medication management as well as pain management was rendered. The disputed services in question were, in fact, reasonable, usual, customary, and medically necessary for treatment of this patient's on-the-job injury. There was sufficient subjective symptomatology and objective documentation on each date of the disputed services to clinically justify the treatment this patient received. In conclusion, the office visits 99213 from 12/13/04 to 01/03/05 were, in fact, medically necessary for the treatment of this patient's on-the-job injury.