



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: Trinity Physical Medicine 2800 Brown Trail Bedford, Texas 76021	MDR Tracking No.: M5-05-3330-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: American Home Assurance Company Box 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION: DWC-60 dispute package

POSITION SUMMARY: Per the table of disputed services "This treatment was necessary as a post surgical rehabilitation program. The patient underwent a lumbar discectomy on July 2, 2004 and this is the first phase of his post surgical rehabilitative therapy. According to the Medicare Fee Guidelines, eighteen sessions of physical therapy is deemed reasonable and necessary, please reprocess accordingly."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION: Response to DWC-60

POSITION SUMMARY: No response submitted by Respondent

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
08-27-04, 10-08-04 and 12-20-04	97113 (11 units total) Note: Amount listed for reimbursement is the amount listed in dispute on the table	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$391.38
08-27-04, 10-08-04, 12-20-04, 01-12-05 and 01-14-05	97530 (5 units total) Note: Amount listed for reimbursement is the amount listed in dispute on the table minus carrier payment for dates of service of 01-12-05 and 01-14-05	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$94.71
01-20-05	97110 (3 units) Note: The carrier submitted information that services have been paid therefore services are no longer in dispute	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$0.00
08-27-04 and 10-08-04	97112	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
01-12-05 and 01-14-05	97110	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
		Total	486.09

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 **prevailed** on the **majority** of the disputed medical necessity issues.

Based on review of the disputed issues within the request, the Medical Review 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 11-22-05, 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.

The carrier has submitted information regarding payment for dates of service 10-05-04, 12-03-04, 12-23-04 and 01-21-05, therefore, these dates of service are no longer in dispute and will not be a part of the review.

Review of CPT code 97140-59 (5 units) dates of service 08-27-04, 09-01-04, 09-03-04, 09-08-04 and 09-14-04 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor submitted convincing evidence of carrier receipt of the providers request for EOBs. Reimbursement is recommended in the amount of **\$143.75 (amount listed on table of disputed services)**.

Review of CPT code 97113 dates of service 09-01-04 (4 units), 09-08-04 (4 units), 09-14-04 (4 units) and 12-22-04 (3 units) revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor submitted convincing evidence of carrier receipt of the providers request for EOBs. Reimbursement is recommended in the amount of **\$533.70 (amount listed on table of disputed services)**.

Review of CPT code 97530 dates of service 09-01-04, 09-03-04, 09-08-04, 09-14-04, 12-13-04 and 12-22-04 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor submitted convincing evidence of carrier receipt of the providers request for EOBs. Reimbursement is recommended in the amount of **\$189.42 (amount listed on table of disputed services)**.

Review of CPT code 97112 dates of service 09-01-04, 09-03-04, 09-08-04 and 09-14-04 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor submitted convincing evidence of carrier receipt of the providers request for EOBs. Reimbursement is recommended in the amount of **\$124.68 (amount listed on table of disputed services)**.

Review of CPT code 97110 (4 units) date of service 09-03-04 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the requestor submitted convincing evidence of carrier receipt of the providers request for an EOB. Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one". The requestor submitted documentation for review that supported the services billed. Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light of all of the Division requirements for proper documentation. Reimbursement is recommended in the amount of **\$124.76 (amount listed on table of disputed services)**.

CPT code 97035 date of service 12-06-04 denied with denial code "F" (Reimbursement according to the Texas Medical Fee Guidelines). The EOB submitted indicated a payment of \$15.30, however, payment information submitted by the carrier on 12-09-05 does not indicate a payment. Reimbursement is recommended in the amount of **\$13.37 (amount listed on table of disputed services)**.

CPT codes 97035, 97140-59 and 97113 date of service 12-13-04 were denied by the carrier with denial code "R" (charge unrelated to compensable injury). On 10-24-05 contact was made with the carrier via telephone and it was confirmed that the question of relatedness to the compensable injury had been resolved for the diagnoses billed for these services in dispute. Reimbursement is recommended in the amounts of **\$13.37, \$28.75 and \$106.74 (amounts listed on the table of disputed services)** respectively.

Review of CPT code 99214-25 date of service 01-14-05 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the requestor submitted convincing evidence of carrier receipt of the providers request for an EOB. Reimbursement is recommended in the amount of **\$89.75 (amount listed on the table of disputed services)**.

Review of HCPCS code L3020 on date of service 01-20-05 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the requestor submitted convincing evidence of carrier receipt of the providers request for an EOB. Reimbursement is recommended in the amount of **\$110.00 (amount listed on the table of disputed services)**.

Review of HCPCS code L3030 on date of service 01-20-05 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the requestor submitted convincing evidence of carrier receipt of the providers request for an EOB. Reimbursement is recommended in the amount of **\$110.00 (amount listed on the table of disputed services)**.

Review of CPT code 97116 (3 units) date of service 01-20-05 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the requestor submitted convincing evidence of carrier receipt of the providers request for an EOB. Reimbursement is recommended in the amount of **\$80.34 (amount listed on the table of disputed services)**.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 133.307(e)(2)(B), 2005 DMEPOS Fee Schedule

PART VII: DIVISION DECISION AND ORDER

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 \$2,154.72. The Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of \$460.00. 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.

Ordered by:

Authorized Signature

01-18-06

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.



CompPartners Peer Review Network
Physician Review Recommendation
Prepared for TDI/DWC

Claimant Name:

Texas IRO # :

MDR#: M5-05-3330-01

Social Security #:

Treating Provider: Trinity Physical Medicine

Review: Chart

State: TX

Amended Date: 1/11/05

Review Data:

- Notification of IRO Assignment dated 11/23/05, 1 page.
- Receipt of Medical Dispute Resolution Request dated 11/22/05, 1 page.
- Medical Dispute Resolution Request/Response dated 8/25/05, 1 page.
- Table of Disputed Services Form, dated 8/27/04, 9/1/04, 9/3/04, 9/8/04, 9/14/04, 10/5/04, 10/8/04, 12/3/04, 12/6/04, 12/13/04, 12/20/04, 12/22/04, 12/23/04, 1/12/05, 1/14/05, 1/20/05, 1/21/05, 2 pages.
- Provider Federal Tax Identification Number and the License/Certification/Registration Number Request Form, 1 page.
- Order of Payment of Independent Review Organization Fee dated 12/6/05, 1 page.
- Explanation of Reimbursement dated 2/14/05, 5 pages.
- Letter of Medical Necessity dated 12/6/05, 2 pages.
- Daily Progress Note dated 1/21/05, 1/20/05, 1/14/05, 1/12/05, 12/23/04, 12/22/04, 12/20/04, 12/13/04, 12/06/04, 12/3/04, 10/8/04, 22 pages.
- SOAP Notes dated 10/5/04, 2 pages.
- Follow-up Examination Report dated 9/14/04, 2 pages.
- Daily Progress Note dated 9/14/04, 9/8/04, 9/3/04, 9/1/04, 8/27/04, 6 pages.

Reason for Assignment by TDI/DWC: Determine the appropriateness of the previously denied (97112) neuromuscular re-education, (97113) aquatic therapy, (97110) therapeutic exercises, and (97530) therapeutic activities, for dates of service 8/27/04 to 1/21/05.

Determination: The previous denial are:

8/27/04 – **PARTIAL – REVERSED** - for 4 units of 97113 aquatic therapy.

PARTIAL – UPHeld - 97112-neuromuscular re-education.

PARTIAL – REVERSED - 97530 therapeutic activities.

10/8/04 – **PARTIAL – REVERSED** - 4 units of 97113 aquatic therapy.

PARTIAL – UPHeld - 97112-neuromuscular re-education.

PARTIAL – REVERSED - 97530-therapeutic activities.

12/20/04 – **PARTIAL – REVERSED** - 4 units of 97113 aquatic therapy.

PARTIAL – REVERSED - 97530 therapeutic activities.

1/12/05 – **PARTIAL – REVERSED** - 3 units of 97110-therapeutic exercises.

PARTIAL – REVERSED - 97530-therapeutic activities.

1/14/05 – **PARTIAL – REVERSED** – 97530-therapeutic activities.

PARTIAL – REVERSED - 3 units of 97110-therapeutic exercises.

1/20/05 – **PARTIAL – REVERSED** - 3 units of 97110-therapeutic exercises.

Rationale:**Patient's age:****Gender:****Date of Injury:** ____**Mechanism of Injury:** Not stated for this review.**Diagnoses:** Post lumbar discectomy L4-5, June 2004 (however, the dispute table indicates surgery on 7/2/05), and post lumbar discectomy from re-surgery on 11/5/04.

This claimant failed a trial of conservative medications and physical therapy and underwent a lumbar discectomy at L4-5 in June of 2004, as indicated by the daily notes from Dr. Blayne Love, DC, (however dispute table indicates surgery on 7/2/04), by orthopedic surgeon Mark J. Cwikkia, MD. He began a course of post surgical rehabilitation with Dr. Love, at the recommendation of Dr. Cwikkia.

The daily progress note from Dr. Love on 8/27/04 indicated he began aquatic therapy on an underwater treadmill, walking at least 20 minutes, and then doing aquatic therapy exercises for a total of 60 minutes. He had bilateral SI joint mobilization performed, myofascial release (not on disputed charges on this date) and therapeutic activities (97530), and neuromuscular re-education (97112). The only objective documentation reflected "palpation of the patient's lumbar spine revealing sensitivity surrounding the incision. Minor edema was noted over the lateral borders of his incision and there was improved soft tissue mobility." There was no documentation of any deficits supporting the medical necessity for neuromuscular re-education, and there was no objective documentation to support the manual therapy mobilization of the bilateral SI joint from posterior to anterior grade 1, as there was no indication of documented subluxation or fixation at this level, and the patient had just had L4-5 discectomy performed in which manipulation would be contraindicated on or near this site without specific recommendation from the surgeon. Specifically, the charge for 4 units of (97113) aquatic therapy, would have been appropriate at this point, post surgically, and the charge for (97530) therapeutic activities would have been appropriate at this point, per the Official Disability Guidelines, but again, the (97112) neuromuscular re-education for this date, is simply not appropriate due to lack of documentation of any deficit.

The 10/8/04 notes from Dr. Love indicated that the surgeon was concerned that the patient had suffered a recurring herniated nucleus pulposus (HNP). Objectively, he had lumbar range of motion in flexion limited to 55/90 degrees, extension limited to 15/25 degrees, right lateral flexion limited to 20/25 degrees and left lateral flexion limited to 15/25 degrees. Straight leg raising was positive at 45 degrees on the right. Charges on that date, were 4-units of (97113) aquatic therapy, (97112) neuromuscular re-education, (97140) manual therapy and (97530) therapeutic activities for 15 minutes. The documentation would support the charges for 4 units of (97113) aquatic therapy, and would support the charge for (97530) therapeutic exercises. Furthermore, the date submitted for review would not support the medical necessity for (97112) neuromuscular re-education due to lack of documented deficits requiring this procedure.

The patient then had another surgical procedure by Dr. Cwikkia, on 11/5/04, and again started post surgical rehabilitation with Dr. Love, on 12/1/04. There was no prescription included for this review for this therapy recommendation, however, Dr. Love documented that the patient did present with one. The actual re-examination on 12/3/04, rated his pain at 4/10, he had mildly right positive straight leg raise, and lumbar range of motion rated at 65/90 degrees, extension 15/25 degrees, left lateral flexion was 20/25 degrees, and right lateral flexion was 15/25 degrees. There were no muscle testing deficits noted, no sensory deficits, there was no documentation of balance or gait disturbances, and there were no subluxation or fixation listings to support manual therapy or soft tissue mobilization. He was the same on 12/6/04, and then on the 12/13/04 visit, he had a flare-up from climbing to install Christmas lights "last week" and was having trouble lifting over 25 pounds. He was seen on 12/20/04, 12/22/04, and 12/23/04 with the same treatment plan.

On the disputed day of service of 12/20/04, the patient was seen and the medical necessity was found within the documentation for: a) 97113-aquatic therapy for 4 units, and medical necessity was also found for: b) 97530-therapeutic exercises. The patient continued with slight improvements, yet remained with significant deficits in ranges of motion along with continued reports of pain post operatively, which was not showing improvement.

On 1/12/05, the documentation reflected subjective pain at 4/10, and was having continued stiffness but was improved, with no radiating pain but continued right gluteal pain. Objectively, the patient still had a positive right straight leg raise, lumbar range of motion near normal with flexion at 85/90 degrees with discomfort, extension at 20/25 degrees, and bilateral lateral flexion at 20/25 degrees. The disputed items included: a) 3 units of (97110)-therapeutic exercises, and b) (97530)-therapeutic activities, both of which, which were found to be a medical necessity with appropriate documentation and reference to the Official Disability Guidelines, p. 147.

On 1/14/05, the charges for 3 units of therapeutic exercises (97110) failed to be a medical necessity, as the same home program exercises were taught the previous date on 1/12/05, and should have not been duplicated, as there was no indication that this patient was having difficulty with them. The charge for (97530)-therapeutic activities is found to be medically necessary per the Official Disability Guidelines.

Criteria/Guidelines utilized: TDI/DWC rules and regulations.

Official Disability Guidelines, 9th edition, 2004, page 147.

ChiroCode Book, 10th edition.

Physician Reviewers Specialty: Chiropractic

Physician Reviewers Qualifications: Texas Licensed DC, BSRT, FIAMA Chiropractor and is also currently listed on the TDI/DWC ADL list.

CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist 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 the decision before the referral to CompPartners, Inc.

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.