



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:

Richard Stephenson DC
322 N Main Street
Bryan TX 77803

MDR Tracking No.: M5-05-3360-01

Claim No.:

Injured Worker'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

DWC-60 package. Position Summary: This dispute is concerning treatment of this patient with conservative care. This treatment was within the initial eight weeks of care and falls within the TWCC Spine Treatment Guidelines and Medicare Treatment Guidelines first phase of care.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Response to DWC-60 package. Position Summary: The office maintains its denial of the disputed services.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
1-31-05 to 4-6-05	97035, 99213, 97124, 97116	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
	99213 15 days X \$50.00 (less than MAR) = \$750.00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$750.00

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 **prevailed** on the majority of

the disputed medical necessity issues.

Based on review of the disputed issues within the request, Medical Review 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 9-16-05, Medical Review submitted a Notice to the 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.

Code 97032 (2 units) billed on dates of service 1-31-05 through 2-5-05 (5 days) – carrier paid one unit with denial code 510 (payment determined) and F (fee guideline MAR reduction). The documentation submitted does not support the two units billed. Documentation simply states in part, “The patient was treated with chiropractic management and adjunctive attended physiotherapy modalities consisting of vibratory massage, ultrasound, and attended mid-range electric stimulation to the areas of complaint. ...” Therefore, no additional reimbursement can be recommended.

The requestor submitted an updated table on 1-26-06 indicating additional services paid. Codes 97032, 97035, 97124 billed on dates of service 2-7-05, 2-8-05, 2-9-05, and 2-10-05 were paid as billed.

Code 97116 billed on dates of service 3-7-05, 3-9-05, 3-11-05, 3-14-05, 3-16-05, 3-24-05, 3-25-05, 3-29-05, 3-30-05, and 4-4-05 was denied as 97 (charge included in another charge) and R84 (CCI, most extensive procedures). Code 97116 is considered to be a component procedure of code 97530 billed on the same date of service. Separate payment for the services billed may be considered if a modifier is used appropriately. Per the CMS 1500, a modifier was not billed with code 97116. Therefore, no reimbursement can be recommended.

Code 97124 (2 units) billed on dates of service 3-7-05, 3-9-05, 3-11-05, 3-24-05, 3-25-05 – carrier paid one unit with denial code 510 (payment determined) and F (fee guideline MAR reduction). The documentation submitted does not support the two units billed. Documentation simply states in part, “The patient was treated with chiropractic management and adjunctive attended physiotherapy modalities consisting of vibratory massage, gait training, and therapeutic activities to the areas of complaint. ...” Therefore, no additional reimbursement can be recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.202

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 additional reimbursement in the amount of \$750.00. In addition, 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:

Medical Dispute Officer

1-27-06

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.

IRO America Inc.

An Independent Review Organization

7626 Parkview Circle

Austin, TX 78731

Phone: 512-346-5040

Fax: 512-692-2924

Amended November 15, 2005

October 19, 2005

TDI-DWC Medical Dispute Resolution

Fax: (512) 804-4868

Patient:

TDI-DWC #:

MDR Tracking #:

IRO #:

_____ M5-05-3360-01

5251

IRO America Inc. (IRO America) has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI, Division of Workers' Compensation (DWC) has assigned this case to IRO America for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

IRO America has performed an independent review of the proposed care 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.

The independent review was performed by a matched peer with the treating doctor; the Reviewer is a credentialed Panel Member of IRO America's Medical Knowledge Panel who is a licensed D.C., board certified and specialized in Chiropractic Care. The reviewer is on the DWC Approved Doctor List (ADL).

The IRO America Panel Member/Reviewer is a health care professional who has signed a certification statement stating that no known conflicts of interest exist between the Reviewer 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 carriers health care providers who reviewed the case for decision before referral to IRO America for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

RECORDS REVIEWED

Medical Records from Requestor, Respondent, Treating Doctor (s), including: MMI evaluations and Impairment Rating from Uma Gullapalli MD, MRI of lumbar spine, lower extremity NCV/EMG, daily notes from treating doctor, medical consult from Steve Opersteny MD, College Station Medical Center medical notes and operative report, FCE notes.

CLINICAL HISTORY

This is a 30 year old female patient who has worked for the _____ for seven years. The Patient has worked with juveniles at a _____ and was injured on _____. The Patient states that she fell on her low back in the cafeteria and injured her low back, mid back and left shoulder. The Patient finished her shift and then saw her chiropractor.

DISPUTED SERVICE(S)

Under dispute is retrospective medical necessity of office visits-99213, ultrasound-97035, massage therapy-97124, and gait training-97116 for dates of service 1/31/2005 through 4/6/2005.

DETERMINATION/DECISION

The Reviewer partially agrees with the determination of the insurance carrier. The Reviewer agrees with the insurance carrier on the following: ultrasound-97035, massage therapy-97124, and gait training-97116; the Reviewer disagrees with insurance carrier on the following: office visits-99213.

RATIONALE/BASIS FOR THE DECISION

Based on the history, and lack of diagnostic medical findings, passive modalities such as ultrasound and massage therapy are not reasonable and not medically necessary. Gait training would not be necessary either since any low tech rehab including phase I and II would re-educate strength, endurance and range of motion into the injured areas. This is outlined in the Texas Workers Compensation Commission Spinal Treatment Guideline §134.1001 and Upper Extremity Guidelines §134.1002. Also, the Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters outlines this as well. Office visits are reasonable to determine the progress and pain levels of the patient as well as to discuss the reports from the diagnostic services performed.

Screening Criteria

1. Specific:

DWC Spinal Treatment Guideline §134.1001, DWC Upper Extremity Guideline §134.1002, Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters.

2. General:

In making his determination, the Reviewer had reviewed medically acceptable screening criteria relevant to the case, which may include but is not limited to any of the following: Evidence Based Medicine Guidelines (Helsinki, Finland); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Texas Chiropractic Association: Texas Guidelines to Quality Assurance (Austin Texas); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Mercy Center Guidelines of Quality Assurance; any and all guidelines issued by DWC or other State of Texas Agencies; standards contained in Medicare Coverage Database; ACOEM Guidelines; peer-reviewed literate and scientific studies that meet nationally recognized standards; standard references compendia; and findings; studies conducted under the auspices of federal government agencies and research institutes; the findings of any national board

recognized by the National Institutes of Health; peer reviewed abstracts submitted for presentation at major medical associates meetings; any other recognized authorities and systems of evaluation that are relevant.

CERTIFICATION BY OFFICER

IRO America has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. IRO America has made no determinations regarding benefits available under the injured employee's policy.

As an officer of IRO America Inc., I certify that there is no known conflict between the Reviewer, IRO America and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

IRO America is forwarding by mail or facsimile, a copy of this finding to the DWC, the Injured Employee, the Respondent, the Requestor, and the Treating Doctor.

Sincerely,

IRO America Inc.



Dr. Roger Glenn Brown

President & Chief Resolutions Officer

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.

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.