



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:
 Summit Rehabilitation Centers
 2500 W Freeway # 200
 Fort Worth, Texas 76102

MDR Tracking No.: M5-06-0015-01

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 SUBMITTED: DWC-60 dispute package
 POSITION SUMMARY: Requestor did not submit a position statement

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60
 POSITION SUMMARY: This is a mixed dispute involving both retrospective medical necessity and fee reimbursement issues. The dates of service in dispute are 8/19/04 to 5/12/05. Carrier asserts that these services were neither reasonable or necessary to treat the compensable injury. Carrier further asserts that it has issued appropriate reimbursement under applicable fee guidelines for the services that are not disputed on medical necessity grounds.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
09-15-04 09-27-04 to 10-06-04 10-19-04 12-28-04 03-30-05 05-10-05 to 05-12-05	*97010 (see note below), 95831, 95832, 97018, 97110, 97140, G0283, 99213 and 95851 *97010- Code 97010 is a bundled service code and considered to be an integral part of a therapeutic procedure(s). Reimbursement for code 97010 is included in the reimbursement for the comprehensive therapeutic code, therefore, additional payment cannot be recommended.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,225.20
10-25-04	95831 and 95832	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00

05-10-05

96004

 Yes No

\$0.00

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, 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.

Dates of service 08-19-04 through 08-26-04 per Rule 133.308(e)(1) were not timely filed and will not be a part of the review.

CPT code 99213 date of service 08-31-04 was withdrawn by the Requestor on 12-30-05 and will not be a part of the review.

On 09-22-05, 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 95851 dates of service 08/30/04, 09/20/04, 11/01/04, 11/16/04, 01/12/05, 03/03/05 and 03/14/05 were denied by the carrier as global (by clinical practice standards, this procedure is incidental to the related primary procedure billed). Per the 2002 Medical Fee Guideline CPT code 95851 is considered to be a component procedure of code 99213 and there are no circumstances in which a modifier would be appropriate. The services represented by the code combination will not be paid separately. Code 99213 was billed along with 95851 on all dates of service except 09-20-04, therefore no reimbursement is recommended. Code 95851 is also considered a component procedure of code 97140. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be considered justifiable if a modifier is used appropriately. Code 97140 was billed on date of service 09-20-04 along with code 95851. No modifier was billed with 95851, therefore no reimbursement is recommended for this date of service either.

CPT code 95831 dates of service 09-07-04, 09-14-04 and 03-21-05 were denied by the carrier as global (by clinical practice standards, this procedure is incidental to the related primary procedure billed). Per the 2002 Medical Fee Guideline CPT code 95831 is considered to be a component procedure of code 99213 and there are no circumstances in which a modifier would be appropriate. The services represented by the code combination will not be paid separately. Code 99213 was billed along with code 95831 on the dates of service in dispute. No reimbursement is recommended.

CPT code 97010 dates of service 09-08-04 and 09-14-04 denied by the carrier as global (this is a bundled procedure, no separate payment allowed). Code 97010 is a bundled service code and considered to be an integral part of a therapeutic procedure(s). Reimbursement for code 97010 is included in the reimbursement for the comprehensive therapeutic code, therefore, additional payment cannot be recommended.

Review of CPT code 99080-73 date of service 10-19-04 revealed that neither party submitted a copy of the EOB. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for an EOB. Reimbursement is recommended in the amount of **\$15.00**.

CPT code 97110 (2 units) date of service 11-16-04 was denied by the carrier as “the charge for this procedure exceeds the fee schedule or usual and customary allowance”. Per Rule 133.307(g)(3)(A-F) the requestor submitted documentation supporting the services billed. Reimbursement is recommended in the amount of **\$72.28** per Rule 134.202(c)(1).

CPT code 95832 dates of service 03-03-05 and 03-21-05 denied by the carrier as global (by clinical practice standards, this procedure is incidental to the related primary procedure billed). Per the 2002 Medical Fee Guideline code 95832 is considered to be a component procedure of code 99213 billed on the dates of service in dispute. There are no circumstances in which a modifier would be appropriate. The services represented by the code combination will not be paid separately.

CPT code 95831 date of service 05-02-05 was denied by the carrier as “this procedure code or National Drug Code (NDC) is not valid for this date of service. Resubmit the bill with a valid procedure code or National Drug Code (NDC). Per the 2002 Medical Fee Guideline code 95831 is a valid code, however, code 95831 per the 2002 Medical Fee Guideline is a component procedure code of 99213 billed on the date of service in dispute. There are no circumstances in which a modifier would be appropriate. The services represented by the code combination will not be paid separately. Reimbursement is not recommended.

CPT code 95832 date of service 05-02-05 was denied by the carrier as “this procedure code or National Drug Code (NDC) is not valid for this date of service. Resubmit the bill with a valid procedure code or National Drug Code (NDC).” Per the 2002 Medical Fee Guideline code 95832 is a valid code, however, code 95832 per the 2002 Medical Fee Guideline is a component procedure code of 99213 billed on the date of service in dispute. There are no circumstances in which a modifier would be appropriate. The services represented by the code combination will not be paid separately. Reimbursement is not recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, Rules 133.307(e)(2)(B), 133.307(g)(3)(A-F) and 134.202(c)(1)

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 \$1,312.48. 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:

Authorized Signature

01-09-06

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.

Parker Healthcare Management Organization, Inc.

4030 N. Beltline Road, Irving, TX 75038
972.906.0603 972.255.9712 (fax)
Certificate # 5301

October 25, 2005

Amended on December 14, 2005

ATTN: Program Administrator

Texas Department of Insurance/Workers Compensation Division

7551 Metro Center Drive, Suite 100

Austin, TX 78744

Delivered by fax: 512.804.4868

Notice of Determination

MDR TRACKING NUMBER: M5-06-0015-01
RE: Independent review for ____

The independent review for the patient named above has been completed.

- Parker Healthcare Management received notification of independent review on 9.21.05.
- Faxed request for provider records made on 9.22.05.
- The case was assigned to a reviewer on 10.7.05.
- The reviewer rendered a determination on 10.24.05.
- The Notice of Determination was sent on 10.25.05.

The findings of the independent review are as follows:

Questions for Review

The therapy in dispute includes: office visits (99213), manual therapy technique (97140), hot/cold packs (97010), muscle testing of the extremity (95831), hand muscle testing (95832), paraffin bath (97018), therapeutic exercise (97110), electrical stimulation unattended (G0283), ROM measurements (95851), physician review and interpretation of comprehensive computer based analysis with written report (96004). The dates of service in question are from 9.15.04 thru 5.12.05. The items denied for "FEE" were not reviewed.

Determination

PHMO, Inc. has performed an independent review of the proposed care to determine if the adverse determination was appropriate. After review of all medical records received from both parties involved, the PHMO, Inc. physician reviewer has determined to **uphold the denial** on the reviewed service(s) that occurred on date of service 10.25.04, per the Table of Disputed charges, which included: CPT code(s) muscle testing of the extremity (95831) and hand muscle testing (95832). It is also determined to **uphold the denial** on CPT code 96004, physician review and interpretation of comprehensive computer based analysis with written report, that occurred on 5.10.05.

The PHMO, Inc. physician reviewer has also determined to **overturn the denial** on all of the other reviewed service(s) that were denied due to medical necessity between the dates of 9.15.04-5.12.05 (excluding 10.25.04), which would include CPT codes per the Table of Disputed charges: office visits (99213), manual therapy technique (97140), hot/cold packs (97010), muscle testing of the extremity (95831), hand muscle testing (95832), paraffin bath (97018), therapeutic exercise (97110), electrical stimulation unattended (G0283), ROM measurements (95851).

Summary of Clinical History

The claimant sustained a work related injury that involves the bilateral upper extremities, distally. The diagnoses include carpal tunnel syndrome. The injury was apparently sustained as a result of a report of repetitive motion injury while at work.

Since the time of the accident, the claimant has received a large amount of conservative care and has also received outside consults and diagnostic studies. There was an EDX study performed that revealed diagnoses of a right sided median motor nerve neuropathy. This is a questionable diagnosis. Typically when a peripheral nerve is entrapped it will not involve just the motor portion of a nerve without sensory findings being involved as well. Also, when the median motor nerve study was performed in this case, the distal onset CMAP latency values were completely normal, bilaterally. The conduction velocity was stated as pathologic, however, conduction velocities are not typically looked at distally, only the distal latencies are evaluated. Having said this, the EDX study was completely normal. There apparently was a carpal tunnel release that was done on 11.18.04. Therapy was provided before and after the date of the surgery.

Clinical Rationale

During the time period before surgery or between the dates of 9.15.04 thru 10.19.04, the claimant did not demonstrate improvement with wrist radial or ulnar deviation. There was noted improvement with wrist flexion, however right wrist extension got worse. Grip strength stayed the same during this time and isometric strength stayed on average the same. The pain levels remained similar. Ultimately the therapy initially failed and surgery was offered for the patient on 11.18.04. As a result, care offered between the dates of 10.25.04 and the date of surgery, 11.18.04, this care should not be considered medically necessary.

After the surgery, the recovery started out slow for the claimant and digression was noted early on, then progression. This is typical post surgically. By the date of 5.12.05, the claimant had improved significantly in grip strength, pain perception, range of motion and strength. All of the disputed care was adequate, initially, for a one month time period between the dates of 9.15.04 thru 10.19.04. Improvement ceased and surgery was offered on 11.18.04. Post surgical rehabilitation is a reasonable form of care and the rehabilitation continued to demonstrate improvement from the date of surgery, 11.18.04, thru the final date in question which is 5.12.05.

The services of physician review and interpretation should not be reimbursed, at any point, because these types of services are considered inclusive with the service that was performed to be interpreted.

Clinical Criteria, Utilization Guidelines or other material referenced

- *Occupational Medicine Practice Guidelines*, Second Edition.
 - *The Medical Disability Advisor*, Presley Reed MD
 - *A Doctors Guide to Record Keeping*, Utilization Management and Review, Gregg Fisher
-

The reviewer for this case is a doctor of chiropractic peer matched with the provider that rendered the care in dispute. The reviewer is a diplomate of the American Chiropractic Neurology Board, and serves as an Associate Professor with the Carrick Institute. The reviewer has added credentials in clinical nutrition, rehabilitation and electrodiagnostic medicine. The reviewer is engaged in the practice of chiropractic on a full-time basis.

The review was performed in accordance with Texas Insurance Code 21.58C and the rules of Texas Department of Insurance /Division of Workers' Compensation. In accordance with the act and the rules, the review is listed on the DWC's list of approved providers or has a temporary exemption. The review includes the determination and the clinical rationale to support the determination. Specific utilization review criteria or other treatment guidelines used in this review are referenced.

The reviewer signed a certification attesting that no known conflicts-of-interest exist between the reviewer and the treating and/or referring provider, 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. The reviewer also attests that the review was performed without any bias for or against the patient, carrier, or other parties associated with this case.

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 address for the Chief Clerk of Proceedings would be: P.O. Box 17787, Austin, Texas, 78744.

I hereby verify that a copy of this Findings and Decision was faxed to Texas Department of Insurance /Division of Workers Compensation applicable to Commission Rule 102.5 this 25th day of October 2005. An Amendment was requested on the 14th day of December 2005. The Division of Workers Compensation will forward the determination to all parties involved in the case including the requestor, respondent and the injured worker. Per Commission Rule 102.5(d), the date received is deemed to be 5 (five) days from the date mailed and the first working day after the date this Decision was placed in the carrier representative's box.

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.