



**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.: M5-06-0017-01
Richard Stephenson, D. C. 322 North Main St. Bryan, TX 77803	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
Federal Insurance Company, Box 17	Employer's Name:
	Insurance Carrier's No.:

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

Documents include the DWC 60 form, Explanations of Benefits, medical documentation and CMS 1500's. Position summary states, "The claims were denied due to unnecessary treatment without peer review and not being appropriately documented. Appropriate documentation was submitted and is submitted with the dispute. The treatment was medically necessary and in accordance with TWCC and Medicare Treatment Guidelines."

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

Documents include the DWC 60 form, peer review and Explanations of Benefits. Position summary states, "There simply is no medical documentation to substantiate the medical necessity for the treatments provided by Requestor. Additionally, the Requestor has sought reimbursement for services that have been unbundled and that have not been properly documented. The Requestor should not be entitled to any reimbursement for the disputed treatments."

#### 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)
11-17-04 – 3-28-05	99213, 97530, 97124, 97032, 97035	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,624.58

#### 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 majority of the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$1,624.58.

On 10-13-05 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 G0283 on 11-9-04, 11-10-04, 11-12-04, 11-15-04 and 11-17-04 were denied by the Carrier as “G-Unbundling.” The carrier did not state which service this was global to per Rule 133.304 (c) and Rule 134.202(a)(4). Recommend reimbursement per the 2002 MFG of \$67.05 (\$13.41 X 5 DOS).

2 units of CPT code 97035 on 11-9-04, 11-10-04, 11-12-04, 11-15-04, 11-17-04, 11-19-04, 11-22-04, 11-23-04, 11-29-04, 12-1-04, 12-6-04, 12-8-04, 12-10-04, 12-17-04, 12-20-04, 12-21-04, 12-23-04, 12-27-04, 12-29-04 were denied by the Carrier as “N-not appropriately documented.” The requestor provided documentation for 13 dates of service. Recommend reimbursement of \$385.06 (\$29.62 X 13 DOS).

2 units of CPT code 97124 on 11-9-04, 11-10-04, 11-15-04, 11-17-04, 11-19-04, 11-22-04, 11-23-04, 11-29-04, 12-1-04, 12-6-04, 12-8-04, 12-10-04, 12-17-04, 12-20-04, 12-21-04, 12-23-04, 12-27-04, 12-29-04 and 1-3-05 were denied by the Carrier as “N-not appropriately documented.” The requestor provided documentation for 13 dates of service. Recommend reimbursement of \$683.28 (\$52.56 X 13 DOS).

CPT code 99080-73 on 11-15-04 and 2-8-05 were denied by the carrier as “T12 – not completed as required.” The requestor did not provide the report for 11-15-04 for verification. The requestor provided the report for 2-8-05 for verification. Recommend reimbursement of \$15.00.

2 units of CPT code 97032 on 11-23-05, 11-29-04, 12-1-04, 12-6-04, 12-8-04, 12-10-04, 12-17-04, 12-20-04, 12-21-04, 12-23-04, 12-27-04 and 12-29-04 were denied by the Carrier as “N-not appropriately documented.” The requestor provided documentation for 8 dates of service. Recommend reimbursement of \$214.56 (\$26.82 X 8 DOS).

CPT code 97018 on 11-29-04, 12-8-04 and 12-10-04 were denied by the Carrier as “G-Unbundling.” The carrier did not state which service this was global to per Rule 133.304 (c) and Rule 134.202(a)(4). Recommend reimbursement per the 2002 MFG of \$48.00 (\$16.00 X 3 DOS).

2 units of CPT code 97530 on 1-3-05 was denied by the Carrier as “N-not appropriately documented.” The requestor provided documentation. Recommend reimbursement of \$69.30.

CPT code 99213 on 2-8-05 was denied by the carrier as “Code 6.” The carrier gave no valid reason for not reimbursing the requestor. Recommend reimbursement of \$50.00.

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

28 Texas Administrative Code Sec. 133.308, 134.202, 133.304 (c).

#### **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 additional reimbursement in the amount of \$3,156.83. 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:**

Donna Auby

12-12-05

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.**

## NOTICE OF INDEPENDENT REVIEW DECISION

November 22, 2005

Program Administrator  
Medical Review Division  
Division of Workers Compensation  
7551 Metro Center Drive, Suite 100, MS 48  
Austin, TX 78744-1609

RE: Claim #:  
Injured Worker:  
MDR Tracking #: M5-06-0017-01  
IRO Certificate #: IRO4326

TMF Health Quality Institute (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Division of Workers' Compensation (DWC) has assigned the above referenced case to TMF for independent review in accordance with DWC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and the 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. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

### Clinical History

The patient sustained a work-related injury on \_\_\_ in a motor vehicle accident and resulted in soft tissue injury to the cervical, lumbar, and right wrist. The patient has been treated with chiropractic treatments.

### Requested Service(s)

Office visits, therapeutic activities, message therapy, electrical stimulation (manual), and ultrasound provided from 11/17/2004 through 03/28/2004.

### **Decision**

It is determined that the office visits, therapeutic activities, message therapy, electrical stimulation (manual), and ultrasound provided from 11/17/2004 through 03/28/2004 were medically necessary to treat this patient's condition.

### Rationale/Basis for Decision

The patient sustained multiple injured areas with subjective and objective findings. The medical record documentation substantiates the medical necessity for each date that treatment was rendered. She responded appropriately to treatment and was placed at maximum medical improvement on 03/31/2005 with a 9% impairment rating.

This decision by the IRO is deemed to be a DWC decision and order.

## 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.

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for hearing and a **copy of this decision** must be sent to: Chief Clerk of Proceedings/Appeals Clerk, Texas Department of Insurance, Division of Workers' Compensation, P. O. Box 17787, Austin, Texas, 78744, Fax: 512-804-4011.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Gordon B. Strom, Jr.", written in a cursive style.

Gordon B. Strom, Jr., MD  
Director of Medical Assessment

GBS:dm

Attachment