



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:	MDR Tracking No.: M5-06-0123-01
Southeast Health Services P. O. Box 453062 Garland, Texas 75045	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
Dallas ISD, Box 42	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include DWC 60 package. Position summary states, "Please see the attached documentation for clarification of each CPT code."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response.

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)
9-15-04 – 1-3-05	CPT code 99211 (\$27.86 X 15 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$417.90
9-15-04 – 1-3-05	CPT code 98940 (\$33.61 X 6 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$201.66
9-15-04 – 1-3-05	CPT code 98943	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	0
9-15-04 – 1-3-05	CPT code 97110 (\$36.00 X 41 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,476.00
9-15-04 – 1-3-05	CPT code 97750-FC (\$37.05 X 10 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$370.50
9-15-04 – 1-3-05	CPT codes 99214, 97016, 97140, 97140-59, 93799, 97032	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0

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 \$2,466.06.

CPT code 98943 is DOP code. Per Rule 133.304 (i) (1-4) The carrier is required to develop and consistently apply a methodology to determine fair and reasonable reimbursement and explain and document the method used for the calculation.

Based on review of the disputed issues within the request, the 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 11-8-05 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 99214 on 9-15-04 and 9-29-04 was denied by the carrier as "N-11 – not appropriately documented." The requestor provided documentation to support level of service per Rule 133.307(g)(3)(A-F). Recommend reimbursement of \$212.72.

CPT code 97140-59 on 9-16-04, 9-17-04 and 10-4-04 was denied by the carrier as "G-2 – Unbundling." Per the 2002 MFG a modifier is allowed to differentiate between the services provided. The requestor correctly used the "59" modifier. Recommend reimbursement of \$102.39 (\$34.13 X 3 DOS)

CPT code 99354-25 on 9-16-04 was denied by the carrier as "G-2 – Unbundling." Per the 2002 MFG this is not a bundled service. This is an add-on code which must be billed with a primary procedure. The medical notes show a prolonged office visit. The office visit was not billed. Recommend no reimbursement.

CPT code 97024 on 9-16-04, 9-17-04, 9-20-04, 9-21-04, 9-22-04, 9-23-04 and 9-24-04 was denied by the carrier as "G-2 – Unbundling." Per the 2002 MFG this is not a bundled service. Recommend reimbursement of \$54.32 (\$7.76 X 7 DOS).

CPT code 99211 on 10-22-04 was denied by the carrier as "N-11 – not appropriately documented." The requestor provided documentation to support level of service per Rule 133.307(g)(3)(A-F). Recommend reimbursement of \$27.86.

CPT code 97032 on 10-22-04 was denied by the carrier as "N-11 – not appropriately documented." The requestor did not provide documentation on the daily medical notes to support delivery of services per Rule 133.307(g)(3)(A-F). Recommend no reimbursement.

CPT code 97016 on 10-22-04 was denied by the carrier as "N-11 – not appropriately documented." The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Recommend reimbursement of \$18.46.

CPT code 97140-59 on 10-22-04 was denied by the carrier as "N-11 – not appropriately documented." The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Recommend reimbursement of \$34.13.

CPT code 97110 on 10-22-04 was denied by the carrier as "N-11 – not appropriately documented." 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." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Division has reviewed the matters in light all of the requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Reimbursement not recommended.

CPT code 97032 on 10-11-04 was denied by the carrier as "F-fee guideline MAR reduction." The requestor did not provide documentation on the daily medical notes to support delivery of services per Rule 133.307(g)(3)(A-F). Recommend no reimbursement.

CPT code 99080-73 on 9-21-04, 10-29-04 and 11-22-04 was denied by the carrier as "U-unnecessary medical." The IRO reviewer concluded that the office visits on dates of service 9-21-04 and 11-22-04 were medically necessary. The office visit

on 10-29-04 was not medically necessary. Based on Rule 133.308(p)(5) an IRO decision is deemed to be a commission decision and order, therefore reimbursement is recommended only for dates of service 9-21-04 and 11-22-04. Recommend reimbursement of \$30.00 (\$15.00 X 2 DOS).

CPT code 97110 on 10-7-04 and 10-8-04 was denied by the carrier as "F-fee guideline MAR reduction." 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." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Division has reviewed the matters in light all of the requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. No reimbursement recommended.

Regarding CPT code 99455-V4-WP on 1-3-05: Neither the carrier nor the requestor provided EOB's. The requestor did submit convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). The requestor did not provide documentation to support delivery of services per Rule 133.307(g)(3)(A-F) or to enable this reviewer to determine the appropriate fee. No reimbursement recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.307, 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 \$2,945.94 + DOP Code. 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

1-9-06

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.

January 3, 2006

December 19, 2005

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

Re: Medical Dispute Resolution
MDR #: M5-06-0123-01
DWC#:
Injured Employee: ____
DOI: ____
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
M5-06-0123-01

Information Provided for Review:

DWC-60, Table of Disputed Services, EOB's

Information provided by Requestor:

Correspondence

Office Notes 09/16/04 – 01/03/05

PT Notes 09/14/04 – 01/03/05

FCE 12/13/04 – 01/03/05

Radiology 09/25/04 – 10/26/04

Clinical History:

This patient stated that on ____ she was at work stopping a fight when she grabbed a student, lost her balance, and fell onto her right side.

Disputed Services:

Office visits codes 99211 and 99214, chiropractic manipulations 98940 and 98943, therapeutic exercises 97110, electric stimulation 97032, vasopneumatic devices 97016, manual therapy 97140 and 97140-59, unlisted services 93799 and **functional capacity eval 97750**.

Decision:

The reviewer partially agrees with the determination of the insurance carrier in this case.

The reviewer agrees with the insurance carrier on the 99214 office visit, the vasopneumatic devices 97016, manual therapy 97140 and 97140-59, unlisted services 93799, **electric stimulation 97032**. I disagree with the insurance carrier on office visits 99211, chiropractic manipulation 98940 and 98943, therapeutic exercises 97110 and **functional capacity eval 97750**, all for dates of services 09/15/04 through 01/03/05.

Rationale:

This patient was put into a therapeutic exercise program early on, which would prevent any type of doctor dependency or deleterious onset of a chronic condition. The office visit 99214 appears to be an upcode from the history and the injuries listed. That is a re-examination code, and a more appropriate code would be 99213. Therefore, a 99214 office visit is not reasonable or necessary. However, the 99211 ENM code is pertinent for the office visits in order to treat and access the condition of the patient. The chiropractic manipulation to the spine and to the extremity, 98940 and 98943, would be considered reasonable and necessary based off the history and the complaints. The therapeutic exercises are valuable to this patient's recovery to achieve maximum medical improvement early on without risk of re-injury. Therefore, the 97110 would be considered reasonable and medically necessary. The electric stimulation would be considered reasonable and necessary within the first 2-3 weeks of the initial phase of care. However, afterwards this type of therapy no longer becomes reasonable and necessary as the patient has begun an active rehab program. The 97016 vasopneumatic devices would be a redundant service, as the therapeutic exercises, chiropractic manipulation, and electrical stimulation. This is another passive modality that would be duplicated and would not really be considered reasonable and necessary. The manual therapy 97140 and 97140-59 also is not considered reasonable and necessary, whereas the manual therapy breaking up fascia and any kind of soft tissue mobilization would be redundant from both the adjustments, the chiropractic manipulations, and the therapeutic exercise. Any kind of interstitial fluid inflammation would be reduced with the electrical stimulation in the first 2-3 weeks of treatment. Therefore, unbundling the charges with the modifier –59 would still be considered unreasonable and medically unnecessary based off the other treatment provided such as the chiropractic manipulation, therapeutic exercises, and the first 2-3 weeks of the electrical stimulation. The 93799 unlisted service was explained as the results of her testing and course of treatment needed to return to her gainful employment. This is a code that is not necessarily considered reasonable and necessary, whereas those would be explained as part of the daily treatment and the 99210 codes. Any type of multiple units of therapeutic exercises would be only based off the level of activity involved in the active rehab program.

Screening Criteria Utilized:

Texas Workers' Compensation Commission Spinal Treatment Guidelines, subsection 134.1001, and the Texas Workers' Compensation Upper Extremities Treatment Guidelines, subsection 134.1002, and the Texas Guidelines for

Chiropractic Quality Assurance and Practice Parameters.