



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: Southeast Health Services Inc P O BOX 453062 Garland, Texas 75045	MDR Tracking No.: M5-06-0383-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Box 42	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: No position summary submitted by Requestor

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60
POSITION SUMMARY: At the outset it should be noted that the Self-Insured denied the majority of the services at issue for reasons other than medical necessity, such as improper unbundling of global charges. For those very few services remaining, the Self-Insured declined reimbursement as the documentation provided did not support the medical necessity of the billed service.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
01-12-05, 01-14-05, 01-19-05, 01-24-05, 01-28-05 and 02-02-05	97110 (1 unit)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$216.00 (\$36.00 X 6)
01-12-05, 01-14-05, 01-19-05, 01-24-05, 01-28-05 and 02-02-05	97110 (excess of 1 unit billed)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
01-21-05, 02-09-05, 02-11-05 and 02-14-05	97110	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
01-19-05	97016	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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 **did not prevail** 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 11-10-05, 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 99354 date of service 12-17-04 was denied by the carrier with denial code G90 (unbundling). Per the 2002 Medical Fee Guideline code 99354 requires a primary procedure code. Known as an "add-on" code, this code is always performed in addition to the primary service or procedure and must never be reported as a stand-alone code. 99354 must be used in conjunction with 99201-99215, 99241-99245 and 99301-99350, none of these services were billed on the date of service 12-17-04. Reimbursement is not recommended.

CPT code 99214 date of service 12-29-04 was denied by the carrier with denial code G90 (unbundling). Per the 2002 Medical Fee Guideline code 99214 is not global to other services billed on 12-29-04. Reimbursement is recommended in the amount of **\$106.36**.

CPT code 97110 dates of service 01-03-05 (4 units), 01-05-05 (1 unit), 01-07-05 (2 units) and 01-10-05 (2 units) was denied by the carrier with denial code F72 (Fee Guideline MAR reduction). The carrier has made no payment. 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, however, 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. No reimbursement is recommended.

CPT code 93799 dates of service 01-31-05 and 02-22-05 was denied by the carrier with denial code 97H (payment is included in the allowance for another service/procedure). Per the 2002 Medical Fee Guideline code 93799 is not global to the other service billed on the dates of service in dispute. Reimbursement is recommended in the amount of **\$244.00 (\$122.00 X 2 DOS)**.

CPT code 99455 date of service 03-09-05 was denied by the carrier with denial code W1A (Workers Compensation State Fee Schedule Adjustment). The carrier has made a payment of \$107.01. Additional reimbursement in the amount of **\$42.99** is recommended per Rule 134.202.

CPT code 97110 date of service 01-17-05 per the explanation of benefits from the carrier was indicated to have been paid in the amount of \$36.14. The requestor was contacted and verification was made that no payment had been made by the carrier. 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". 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. No reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.202 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 \$609.35. The Division finds that the requestor was not the prevailing party and is not entitled to a refund of the IRO fee. 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:

12-29-05

Authorized Signature

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.

December 15, 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: M5-06-0383-01
RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 11.10.05.
- Faxed request for provider records made on 11.10.05.
- TDI-DWC issued an Order for Payment on 11.21.05.
- The case was assigned to a reviewer on 12.5.05.
- The reviewer rendered a determination on 12.14.05.
- The Notice of Determination was sent on 12.15.05.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of therapeutic exercises (97110) and vasopneumatic devices (97016) for dates of service 1.12.05 through 2.14.05.

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 **overturn the denial** on one denied unit of 97110 (therapeutic exercises) on the dates of service: 1.12.05, 1.14.05, 1.19.05, 1.24.05, 1.28.05, and 2.2.05.

The PHMO, Inc. physician reviewer has also determined to **uphold the denial** on the disputed CPT Code 97016(vasopneumatic devices) and all other units of 97110(therapeutic exercises) in excess of 2 units per date of service.

Summary of Clinical History

Patient is a 46-year-old storekeeper who, on ____, was moving bags of oil absorb, and when he picked one up that weighed an estimated 50 pounds and started to carry it, he experienced a sudden, intense lower back pain. He immediately dropped the bag and then leaned against other stacked bags in an effort to ease his pain. Later, the pain radiated to both legs. He presented to a doctor of chiropractic on 12.16.04 and began a regimen of chiropractic care, physical therapy and rehabilitation.

Clinical Rationale

According to a Medicare Medical Policy Bulletin¹, “The use of vasopneumatic devices (97016) may be considered reasonable and necessary for the application of pressure to an extremity for the purpose of reducing edema. Specific indications for the use of vasopneumatic devices include the reduction of edema after acute injury and lymphedema of an extremity.” However, in this case, there was no mention in the medical record of the presence of edema in the lower back, and the dates of service in dispute for this device occurred 4 weeks post-injury, so the injury was also not acute at that time. Furthermore, the records provided revealed that an examination was performed on 12.29.04 and it documented pain levels at only “0-2 out of a possible 10,” and it reported completely negative orthopedic and neurological findings. Therefore, the use of this device was unsupported as medically necessary.

Insofar as the therapeutic exercises (97110) were concerned, the medical records revealed that these procedures were just introduced on 1.3.05, and it was not even 4 weeks post-injury at that time. Since active therapeutic procedures are an essential part of soft tissue healing, this was an appropriate approach to care. Furthermore, the records documented that a strength deficit existed in the patient, and that the deficit improved over time with treatment (the difference in the FCEs from 1.31.05 and then again on 2.22.05), so the medical necessity of a portion of the therapeutic exercise program was supported.

However, by 1.12.05, the patient was experiencing only a minimal amount of pain (“0-2 out of a possible 10” and doctor’s notes that indicated “low back minimal pain”), and – other than the strength deficit documented on FCE – his reexamination of 12.29.04 was essentially normal in terms of orthopedics and neurology. Therefore, and absent any specific complicating rationale provided within the medical record to substantiate the necessity for supervised exercises in excess of 30 minutes per encounter, the medical necessity of doing so was not supported.

Clinical Criteria, Utilization Guidelines or other material referenced

HGSA Medicare Medical Policy Bulletin, Physical Therapy Rehabilitation Services, original policy effective date 04/01/1993 (Y-1B)

The reviewer for this case is a doctor of chiropractic peer matched with the provider that rendered the care in dispute. 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.

¹ HGSA Medicare Medical Policy Bulletin, Physical Therapy Rehabilitation Services, original policy effective date 04/01/1993 (Y-1B)

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 15th 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.

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.