**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:<br><br>Mega Rehab<br>2800 Forestwood Ste. 130<br>Arlington, TX 76006 | MDR Tracking No.: M5-06-0411-01<br>Claim No.:<br>Injured Employee's Name: |
| Respondent's Name and Address:<br><br>Insurance Company of the State of PA, Box 19 | Date of Injury:<br>Employer's Name:<br>Insurance Carrier's No.: |

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

Documents include the DWC 60 package. Position summary states, "The care is reasonable and necessary and the therapy notes show improvement in the patient's condition."

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

Documents include the DWC 60 response. Position summary states, "Per independent medical examination, treatment is not reasonable and necessary." The carrier did allude to extent of injury issues. In a BRC on 12-16-05 the carrier accepted sprain/strain injuries. This is the injury for which the requestor billed. Therefore, these services are compensable.

**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) |
|---|---|---|---|
| 12-1-04 – 2-8-05 | CPT code 95900 ($61.20 X 6 units - less than MAR) | ☒ Yes ☐ No | $429.96 |
| 12-1-04 – 2-8-05 | CPT code 95903 ($77.59 X 4 units - less than MAR) | ☒ Yes ☐ No | $310.36 |
| 12-1-04 – 2-8-05 | CPT code 95904 ($61.20 X 6 units - less than MAR) | ☒ Yes ☐ No | $367.20 |
| 12-1-04 – 2-8-05 | CPT code 99080 ($25.00 + $50.00) | ☒ Yes ☐ No | $75.00 |
| 12-1-04 – 2-8-05 | CPT code 99214 ($93.96 X 1 DOS - less than MAR) | ☒ Yes ☐ No | $93.96 |
| 12-1-04 – 2-8-05 | CPT code 97750 ($34.48 X 20 units - less than MAR) | ☒ Yes ☐ No | $687.60 |
| | Grand Total | | $1,964.08 |

**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 disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is $1,964.08.

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 1-31-06 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 99455-VR on 2-8-05 was denied by the carrier as "97-payment is included in the allowance for another service/procedure, 45-charges exceed your contracted legislated fee arrangement and 50-These charges are non-covered services because this is not deemed a medical necessity by the payer." Per the 2002 MFG this service is not global to any other service, in a letter dated 1-30-06 the requestor states that there is no contract with this insurance company and this service cannot be denied for medical necessity. A referral will be made to Compliance and Practices for this violation. According to Rule 134.202 (6)(F) the treating doctor shall bill the medical disability examination with modifier "VR" to indicate a review of the report only, and shall be reimbursed $50.00. Recommend reimbursement of $50.00.

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

28 Texas Administrative Code Sec. 133.308 and 134.202.

## 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 $2,014.08. 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 | 2-22-06 |
|---|---|---|
| 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.**

February 17, 2006

TX DEPT OF INS DIV OF WC
AUSTIN, TX 78744-1609

CLAIMANT: ___
EMPLOYEE: ___
POLICY: M5-06-0411-01
CLIENT TRACKING NUMBER: M5-060411-01 5278

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Medical Review Institute of America (MRIoA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Department of Insurance Division of Workers Compensation has assigned the above mentioned case to MRIoA for independent review in accordance with DWC Rule 133 which provides for medical dispute resolution by an IRO.

MRIoA 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. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the DWC approved doctor list (ADL). The reviewing provider has no known conflicts of interest existing between that provider 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 IRO.

**Records Received:**

FROM THE STATE:
Notification of IRO assignment 1/31/06 – 1 page
Texas Department of Insurance Division of Workers Compensation form 1/31/06 – 1 page
Medical dispute resolution request/response form – 2 pages
Provider form – 1 page
Table of disputed services – 1 page
Amended explanation of review 9/8/05 – 3 pages

FROM THE RESPONDENT/Broadspire-American Home Assurance:
Letter from Rick Jacobs/Broadspire 2/6/06 – 1 page
Report of independent medical examination 11/11/04 – 6 pages
Functional capacity assessment 11/11/04 – 10 pages

FROM THE REQUESTOR/Mega Rehab:
Texas Department of Insurance Division of Workers Compensation form 1/31/06 – 2 pages
Medical dispute resolution request/response form (corrected copy) – 1 page
Provider form – 1 page
Table of disputed services – 1 page
Letter from Broadspire 8/4/05 – 1 page
Medical dispute resolution request/response form – 1 page
Provider form – 1 page
Table of disputed services – 3 pages
Work status report 9/9/04 – 1 page
Initial evaluation 9/9/04 – 3 pages
Subsequent evaluation 10/25/04 – 3 pages
Subsequent examination 12/7/04 – 4 pages
Physical therapy progress notes 9/20/04, 9/22/04, 9/27/04, 9/29/04, 9/30/04, 10/4/04, 10/6/04, 10/7/04, 10/14/04, 10/13/04, 10/12/04, 10/18/04, 10/20/04, 10/22/04, 10/25/04, 10/26/04, 10/28/04, 11/02/04, 11/04/04, 11/09/04, 11/12/04, 11/16/04, 11/18/04, 11/19/04, 11/22/04, 11/23/04, 11/24/04, 12/4/04, 12/2/04, 12/3/04, 12/6/04, 12/8/04, 12/9/04, 12/13/04, 12/15/04, 12/16/04, 12/20/04, 12/21/04, 12/23/04 – 39 pages
Physical therapy initial evaluation, 9/17/04 – 4 pages
Physical therapy re-evaluations, 10/22/04, 12/13/04 - 6 pages
Initial outpatient consultation, Gunda Kirk, DO, 9/21/04 – 4 pages
Outpatient follow up visit, Gunda Kirk, DO, 10/14/04 – 3 pages
MRI, Cervical spine, 1/12/05 – 2 pages
Functional Capacity Assessment, 11/11/04 – 10 pages
Electrodiagnostic studies, 11/24/04 – 5 pages
Functional Capacity Evaluation, 2/8/05 – 8 pages

Functional Capacity Evaluation, 5/24/05 – 4 pages
Report of Independent Medical Examination, 11/11/04 – 6 pages
EMG studies, 11/30/04 – 1 page
Initial Outpatient Consultation, 11/30/04 – 3 pages
DWC-69 Report of Medical Evaluation, 12/20/04 – 1 page
Designated Doctor Exam, 12/20/04 – 2 pages
Office notes, Charles Marable, MD, 6/14/05, 9/28/04, 11/17/04 – 5 pages
Nerve conduction studies, Charles Marable, MD, 12/1/04 – 1 page
Work status reports, 7/29/04, 8/6/04, 8/17/04 – 3 pages

**Summary of Treatment/Case History:**
The claimant underwent physical medicine treatments, FCEs, diagnostic imaging, NCV/EMG after sustaining injury at work on ___ when she tripped over a cemented bolt and fell.

**Questions for Review:**

1. Were the #95900, #95903, #95904 – Nerve Conduction Study, #99080 – Special Report, #98214-Office Visit, #97750-FC-FCE (not marked as FEE) from 12/01/04 through 02/0/8/05 medically necessary to treat this patient's injury?

**Explanation of Findings:**
Without question, the FCE and NCV/EMG testing met statutory requirements for medical necessity. In fact, the EMG testing documented that the claimant had "mild bilateral C7 radiculopathies and right C5 nerve root irritation" which assisted the provider's decision making in the care of the claimant. Moreover, the disputed FCE was medically necessary in order to determine the claimant's functional status and did not exceed the statutory authorized number of three FCEs.

**Conclusion/Decision to Certify:**

1. Were the #95900, #95903, #95904 – Nerve Conduction Study, #99080 – Special Report, #98214-Office Visit, #97750-FC-FCE (not marked as FEE) from 12/01/04 through 02/0/8/05 medically necessary to treat this patient's injury?

Yes, the #95900, #95903, #95904 – Nerve Conduction Study, #99080 – Special Report, #98214-Office Visit, #97750-FC-FCE (not marked as FEE) from 12/01/04 through 02/0/8/05 were medically necessary.

**Applicable Clinical of Scientific Criteria or Guidelines Applied in Arriving at Decision:**
Texas Labor Code 408.021

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This review was provided by a chiropractor licensed in Texas, certified by the National Board of Chiropractic Examiners, and who is a member of the American Chiropractic Association and has several years of licensing board experience. This reviewer has written numerous publications and given several presentations with their field of specialty. This reviewer has been in continuous active practice for over twenty-five years.

MRIoA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the DWC.

It is the policy of Medical Review Institute of America to keep the names of its reviewing physicians confidential. Accordingly, the identity of the reviewing physician will only be released as required by state or federal regulations. If release of the review to a third party, including an insured and/or provider, is necessary, all applicable state and federal regulations must be followed.

Medical Review Institute of America retains qualified independent physician reviewers and clinical advisors who perform peer case reviews as requested by MRIoA clients. These physician reviewers and clinical advisors are independent contractors who are credentialed in accordance with their particular specialties, the standards of the American Accreditation Health Care Commission (URAC), and/or other state and federal regulatory requirements.

The written opinions provided by MRIoA represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to MRIoA for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Medical Review Institute of America assumes no liability for the opinions of its contracted physicians and/or clinician advisors. The health plan, organization or other party authorizing this case review agrees to hold MRIoA harmless for any and all claims which may arise as a result of this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

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Case Analyst: Valerie O ext 554