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.: M5-06-0425-01
Integra Specialty Group, P. A. 517 North Carrier Parkway, Suite G Grand Prairie, TX 75050	Claim No.:
	Injured Employee's Name:
Texas Mutual Insurance Company, Box 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include DWC 60 package. Position summary states, "The carrier failed to provide any request for reconsideration response EOB's for any of the outstanding dates of service."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include DWC 60 response. "Texas Mutual requests that the request for dispute resolution filed by Horizon Health be conducted under the provisions of the APA set out above."

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)
3-30-05 – 7-25-05	CPT code 97110 ($36.14 X 38 units)	☒ Yes ☐ No	$1,373.32
3-30-05 – 7-25-05	CPT code 95851 – see below	☒ Yes ☐ No	0
3-30-05 – 7-25-05	CPT code 97032 ($20.20 X 38 units)	☒ Yes ☐ No	$767.60
3-30-05 – 7-25-05	CPT code 99211	☒ Yes ☐ No	$27.86
3-30-05 – 7-25-05	CPT code 99212 ($48.99 X 4 DOS)	☒ Yes ☐ No	$195.96
3-30-05 – 7-25-05	CPT code 97112 ($38.15 X 14 DOS)	☒ Yes ☐ No	$534.10
3-30-05 – 7-25-05	CPT code 97140 ($34.13 X 15 DOS)	☒ Yes ☐ No	$511.95
3-30-05 – 7-25-05	CPT code 99213	☐ Yes ☒ 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.

CPT codes 99204 on 3-30-05, 73600 on 3-30-05, 95851 on 5-26-05 and 99213 on 6-8-05 were withdrawn by the requestor and will not be a part of this review.

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 $3,410.79.

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 11-17-05 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 99213 on 4-26-05 was denied by the carrier as "242-Not treating doctor approved treatment." The doctor who performed this service is not on the TDI Approved Doctor List. Recommend no reimbursement.

Upon resubmission by the requestor to the insurance carrier CPT code 95851 on 5-26-05 was denied by the carrier as "143-Portion of payment deferred." Per the 2002 MFG the MAR for this service is $26.29. The carrier has reimbursed $12.19. Recommend additional reimbursement of $14.10.

CPT code 95851 on 7-5-05 was denied by the carrier as "97-Payment is included in the allowance for another procedure." Per the 2002 MFG CPT code 95851 is considered by Medicare to be a component procedure of CPT code 99212. 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 99212 was billed on the same date. Recommend no reimbursement.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and Rule 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 $3,424.89. 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:

		1-26-06
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.

NOTICE OF INDEPENDENT REVIEW DECISION

January 19, 2006

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 #: M5-06-0425-01
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

This patient sustained a work-related injury on ___ when he got his foot caught in a crack and suffered a severe fracture. The patient had undergone open reduction and internal fixation with hardware and a bone growth stimulator. A portion of his treatment included chiropractic care.

Requested Service(s)

(97110) therapeutic exercises, (95851) ROM measurements, (99213/99211/99212) office visits, (97112) neuromuscular re-education, and (97140) manual therapy technique provided from 03/30/2005 through 07/25/2005.

Decision

It is determined that the (97110) therapeutic exercises, (95851) ROM measurements, (99211/99212) office visits, (97112) neuromuscular re-education, and (97140) manual therapy technique provided from 03/30/2005 through 07/25/2005 were medically necessary to treat this patient's condition.

It is determined that the office visits coded (99213) were not medically necessary.

Rationale/Basis for Decision

Expectation of improvement in a patient's condition should be established based on success of treatment. Continued treatment is expected to improve the patient's condition and initiate restoration of function. If treatment does no produce the expected positive results, it is not reasonable to continue that course of treatment. With documentation of improvement in the patient's condition and restoration of function, continued treatment may be reasonable and necessary to effect additional gains.

In this case, there is adequate documentation of objective and functional improvement in this patient's condition. Specifically, the patient's pain ratings decreased and he was cleared for work on 07/25/2005. Therefore, the medical records fully substantiate that the disputed services fulfilled statutory requirements1 for medical necessity since the patient obtained relief, promotion of recovery was accomplished, and there was an enhancement of the employee's ability to return to employment.

However, based on CPT2, there is no support for the medical necessity for the high level of E/M service (99213) for dates of service during what was an established treatment plan.

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 that 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,

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

1 Texas Labor Code 408.021
2 *CPT 2004: Physician's Current Procedural Terminology, Fourth Edition, Revised* (American Medical Association, Chicago, Il 1999),