



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.: M5-06-0480-01
Summit Rehabilitation Centers 2500 W. Freeway #200 Ft. Worth, TX 76102	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
TX Mutual Insurance Company, Box 54	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 package. "Provider sent a request for reconsideration. Proof that carrier received request is also included. Carrier chose not to respond within the 28 day time frame rule."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response. Position summary states, "Texas Mutual requests that the request for dispute resolution filed 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)
11-01-04 – 5-31-05	CPT code 97140 and 97140-59 (\$34.16 x 25 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$854.00
11-01-04 – 5-31-05	CPT code 98940 (\$33.61 x 15 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$504.15
11-01-04 – 5-31-05	CPT codes 97710, G0283, 97012, 99213, 95833, 95831, 97018, 96004	<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.

In accordance with Rule 133.308 (e), requests for medical dispute resolution are considered timely if they are filed with the division no later than one year after the dates of service in dispute. The following dates of service are not eligible for this review: 9-29-04 – 10-28-04.

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. The amount due the requestor for the items denied for medical necessity is \$1,358.15.

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 12-1-05 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.

The requestor has submitted for Medical Dispute Resolution numerous charges which are global to others on the same date of service. Rule 133.1(a)(3)(C) states that a complete medical bill includes correct billing codes from Commission fee guidelines in effect on the date of service. The requestor will be billed for not following this rule.

CPT code 97140 on 11-1-04 was denied by the carrier as "434-The value of this procedure is included in the value of the mutually exclusive procedure." This CPT code is global to CPT code 98940 which was billed on this date of service. Recommend no reimbursement.

Three units of CPT code 97110 on 11-2-04 were denied by the carrier as "790-The charge was reduced in accordance to the Texas Medical Fee Guideline." The MAR for this service is \$36.99. The carrier has reimbursed this amount. Recommend no additional reimbursement.

CPT code 95851 on 11-8-04 and 11-17-04 was denied by the carrier as "435-The value of this procedure is included in the value of the comprehensive procedure" or as "790-The charge was reduced in accordance to the Texas Medical Fee Guideline." This CPT code is global to CPT code 99213 which was billed on this date of service. Recommend no reimbursement.

Regarding CPT code 99372 on 11-11-04: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). Per the 2002 MFG this code is a bundled service. No reimbursement recommended.

CPT code 99213 on 11-17-04 was denied by the carrier as "864-E/M services may be reported only if the patient's condition requires a significant separately identifiable procedure." There were no office notes submitted to enable the Division to ascertain whether this service meets the documentation criteria set forth by the CPT Code descriptor for this CPT code. Reimbursement is not recommended.

CPT code 97140-59 on 11-22-04 was denied by the carrier as "893-This code is invalid, not covered or has been deleted from the Texas Fee Schedule." This is a valid code and a modifier was used to differentiate between the services. However, there was no documentation to support the modifier. Recommend no reimbursement.

CPT code 98940 on 11-22-04 was denied by the carrier as "893-This code is invalid, not covered or has been deleted from the Texas Fee Schedule." Per the 2002 MFG this is a valid CPT code. Recommend reimbursement of \$33.61.

CPT code 95834 on 11-22-04 was denied by the carrier as "435-The value of this procedure is included in the value of the comprehensive procedure." This CPT code is global to CPT code 98940 which was billed on this date of service. Recommend no reimbursement.

CPT code 97750-FC on 11-29-04 was denied by the carrier as "435-The value of this procedure is included in the value of the comprehensive procedure." Per the 2002 MFG this service is not global to another service performed on this date of service. Recommend reimbursement of \$592.80.

CPT code 95831 on 12-27-04 was denied by the carrier as "435-The value of this procedure is included in the value of the

comprehensive procedure.” This CPT code is global to CPT code 99213 which was billed on this date of service. Recommend no reimbursement.

CPT code 95851 on 12-27-04 was denied by the carrier as “435-The value of this procedure is included in the value of the comprehensive procedure.” This CPT code is global to CPT code 98940 which was billed on this date of service. Recommend no reimbursement.

CPT code 98940 on 1-3-05 and 5-31-05 was denied by the carrier as “255-This charge does not appear to be applicable in this case.” There were no office notes submitted to support this service. Recommend no reimbursement.

CPT code 95851 on 4-05-05 and 4-19-05 was denied by the carrier as “97-Payment is included in the allowance for another procedure.” This CPT code is global to CPT code 99213 which was billed on this date of service. Recommend no reimbursement.

CPT code 96004 on 4-19-05 and 5-4-05 was denied by the carrier as “97-Payment is included in the allowance for another procedure.” Per the 2002 MFG this code is not global to another CPT code billed on this date. Recommend reimbursement of \$310.50 (\$155.25 X 2 DOS).

CPT code 99199 on 3-22-05 was denied by the carrier as “225-the submitted documentation does not support the service being billed. We will reevaluate this upon receipt of clarifying information.” There were no office notes submitted to support this service. Recommend no reimbursement.

CPT code 99354 on 4-25-05 was denied by the carrier as “225-the submitted documentation does not support the service being billed. We will reevaluate this upon receipt of clarifying information.” There were no office notes submitted to support this service. Recommend no reimbursement.

CPT code 95831 on 5-4-05 was denied by the carrier as “97-Payment is included in the allowance for another procedure.” Per the 2002 MFG this code is global to CPT code 99213 which was billed on this date. Recommend no reimbursement

CPT code 95832 on 5-4-05 was denied by the carrier as “97-Payment is included in the allowance for another procedure.” Per the 2002 MFG this code is global to CPT code 99213 which was billed on this date. Recommend no reimbursement

CPT code 97012 on 5-11-05 was denied by the carrier as “CAC-16- Claim/service lacks information which is needed for adjudication.” The requestor provided no documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Recommend no reimbursement.

CPT code 97018 on 5-11-05 was denied by the carrier as “CAC-16- Claim/service lacks information which is needed for adjudication.” The requestor provided no documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Recommend no reimbursement.

CPT code 97110 on 5-11-05 was denied by the carrier as “CAC-16- Claim/service lacks information which is needed for adjudication.” The requestor provided no documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Recommend no reimbursement.

CPT code 97140-59 on 5-11-05 was denied by the carrier as “CAC-16- Claim/service lacks information which is needed for adjudication.” The requestor provided no documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Recommend no reimbursement.

CPT code 98940 on 5-11-05 was denied by the carrier as “Rule 133.1 requires the submission of legible supporting documentation; therefore, reimbursement is denied.” The requestor provided no documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Recommend no reimbursement.

CPT code 99213 on 5-11-05 was denied by the carrier as “Rule 133.1 requires the submission of legible supporting documentation; therefore, reimbursement is denied.” The requestor provided no documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Recommend no reimbursement.

CPT code G0283 on 5-11-05 was denied by the carrier as "Rule 133.1 requires the submission of legible supporting documentation; therefore, reimbursement is denied." The requestor provided no documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Recommend no reimbursement.

CPT code 99080-73 on 2-28-05 and 5-31-05 was denied by the carrier as "248-not properly documented." The requestor provided no documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Recommend no reimbursement.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 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 Division has determined that the requestor is not entitled to a refund of the paid IRO fee. The Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute in the amount of 2,295.06. 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

2-3-06

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 18, 2006

Amended Letter: January 31, 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 #: M5-06-0480-01
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 she struck her right arm on a piece of machinery and got her shirt caught in the machinery. She injured her right wrist, shoulder, neck, and right shoulder. A portion of the patient's care included chiropractic care.

Requested Service(s)

(97110) therapeutic exercises, (97140/97140-59) manual therapy technique, (G0283) electrical stimulation, (97012) mechanical traction, (99213) office visits, (95833) muscle test whole body, (95831) muscle testing, (97018) paraffin bath, (98940) chiropractic manipulative treatment, (96004) physician review & interpretation of comprehensive computer based motion analysis, dynamic plantar measure etc. with written report, provided from 11/01/2004 through 05/31/2005.

Decision

It is determined that the (97140/97140-59) manual therapy technique and the (98940) chiropractic manipulative treatment provided from 11/01/2004 through 05/31/2005 were medically necessary to treat this patient's condition.

It is determined that the (97110) therapeutic exercises, (G0283) electrical stimulation, (97012) mechanical traction, (99213) office visits, (95833) muscle test whole body, (95831) muscle testing, (97018) paraffin bath, (96004) physician review & interpretation of comprehensive computer based motion analysis, dynamic plantar measure etc. with written report, provided from 11/01/2004 through 05/31/2005 were not medically necessary.

Rationale/Basis for Decision

In this case, the medical records adequately documented decreased range of motion and the presence of pain in both the cervical spine as well as the right upper extremity. Therefore, chiropractic manipulative therapy (98940) and manual therapy techniques (97140 and 97140-59) in the form of joint mobilization and myofascial release to these areas, was supported as medically necessary.

However, in terms of the whole body range of motion testing (95833) and the muscle testing procedures (95831), these services were not medically necessary because, according to CPT¹, they are normally procedures that are components of Evaluation and Management (E/M) services. Since the records reflected that separate E/M services were also performed on the dates that tests were performed – and, since there was no documented clinical rationale supporting why these tests needed to be performed as separate, distinct tests – performing them again was duplicative and as such, not medically necessary.

Insofar as the therapeutic exercises (97110) were concerned, nothing in either the diagnosis or medical records supported the medical necessity for the fourth unit of this service (four units were reported and three were paid for each date of service, so only the fourth unit was in dispute in this case). Not only was the injury limited to a relatively small body part, but also, the patient could have been safely transitioned into a home program to augment what was being done in the clinical setting. This is further supported by the fact that, according to the medical literature "...there is no strong evidence for the effectiveness of supervised training as compared to home exercises."² Therefore, the 4th unit of this service was not supported as medically necessary.

In terms of the level III established patient office visits (99213), nothing in either the diagnosis or the medical records supported the performance of so high a level E/M service on such a routine, day-to-day bases, particularly not during an already-established treatment plan and when the patient was under concurrent care with so many physicians. Rather, this was duplicative work and accordingly, unsupported as medically necessary.

Regarding the electrical stimulation, unattended (G0283), the NASS Guidelines³ state that passive interventions are indicated during the first 8 weeks only "if clinically indicated and not previously unsuccessful."

However, in this case, utilization of this service by as late a date as 01/24/2005 was well beyond the window of what would be considered appropriate for passive modalities, particularly in the face of limited response on the part of the patient.

In terms of the mechanical traction (97012), the records were devoid of any rationale regarding the appropriateness of this service. First of all, the cervical MRI was essentially negative, and it was determined from the diagnostics that most of the shoulder, wrist and hand symptoms were arising intrinsically from the upper extremity itself. Furthermore, according to *Applied Physiotherapy*⁴ the indications for this modality are to "(1) reduce congestion in chronic musculoskeletal disorders and (2) provide increased mobility in patients with arthritic complaints." Since neither of these findings were documented in the medical record for this patient, the application of this service to the cervical spine was not supported as medically necessary.

Relative to the paraffin bath treatments (97018) rendered on 02/16/2005, 02/17/2005, these were all done prior to 02/24/2005 carpal tunnel release surgery. Again, according to *Applied Physiotherapy*, p. 152, "Paraffin should not be used...where there is diminished sensation." Since the medical records repeatedly documented

1 CPT 2004: *Physician's Current Procedural Terminology, Fourth Edition, Revised*, (American Medical Association, Chicago, IL 1999)

2 Ostelo RW, de Vet HC, Waddell G, Kerchhoffs MR, Leffers P, Van Tulder M, Rehabilitation following first-time lumbar disc surgery: a systematic review within the framework of the conchran collaboration. *Spine*. 2003 Feb 1;28(3):209-18

3 North American Spine Society phase III clinical guidelines for multidisciplinary spine care specialists, 2000

4 *Applied Physiotherapy, Practical Clinical Application with Emphasis on the Management of Pain and Related Syndromes*, Pl Jaskoviak, et. al., American Chiropractic Association, First Edition, p. 348-349

numbness and tingling in the right upper extremity due to the carpal tunnel entrapment, this treatment was not only medically unnecessary but also contraindicated.

Regarding the 96004, according to CPT5, this service is defined as, "Physician review and interpretation of comprehensive computer-based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report." However, this injury does not involve the lower extremities, so "dynamic plantar measurements" and "dynamic surface electromyography during walking" are irrelevant in this case and therefore not medically necessary. Furthermore, the code requires that a written report be submitted, and upon careful review of the doctor's records, the statement, "I review and signed the Jtech ROM/MT exam given to Lidia and will adjust treatment protocols as needed" is insufficient to qualify as a "written report."

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.

Sincerely,

A handwritten signature in black ink that reads "Gordon B. Strom, Jr." The signature is written in a cursive, somewhat stylized font.

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

GBS:dm

Attachment