



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.: M5-06-0500-01
Texas Injury Consultants, Ltd. 2646 South Loop West #650 Houston, TX 77054	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
Metropolitan Transit Authority, Box 19	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 package. Position summary states, "The treatment was prolonged due to multiple complicating factors including diabetes mellitus and injuries to multiple body areas. The treatment was reasonable and medically necessary."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response. Position summary states, "The billing was denied as there was no documentation of a treatment plan as required by CMS. Otherwise all treatment provided on and after 1-5-05 was denied as not medically necessary per the Peer Review of December 21, 2004."

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)
12-01-04 – 02-28-05	CPT code 97110 (\$35.69 X 6 DOS) CPT code 97110 (\$34.93 X 24 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$214.14 \$1676.64
11-3-04 - 11-30-04	CPT code 97140 (\$32.90 X 10 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$329.00
11-3-04 - 11-30-04	CPT code 97032 (\$19.46 X 10 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$194.60
11-3-04 – 02-28-05	CPT code 99213 (\$65.18 X 19 DOS) CPT code 99213 (\$65.44 X 24 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1238.42 1570.56
12-01-04 – 02-28-05	CPT code 97530 (\$36.11 X 6 DOS) CPT code 97530 (\$36.78 X 24 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$216.66 \$882.72
11-18-04 – 1-10-05	CPT codes 97110, 97140, 97032, 99213, 97530 (except as noted above) 97124	<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), dates of service 10-29-04 and 11-01-04 were not timely filed and are not eligible for this review.

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 \$6,322.74.

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 12-2-05 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.

Code 97010, which was billed on numerous dates of service, is a bundled service code and considered to be an integral part of a therapeutic procedure(s). Reimbursement for code 97010 is included in the reimbursement for the comprehensive therapeutic code. Therefore, additional payment cannot be recommended.

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 \$6,322.74. 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 by:

1-25-06

Order by:

Margaret Ojeda

1-25-06

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 13, 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 #: M5-06-0500-01
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 to his neck and back on ___ when as a bus operator, he was involved in a motor vehicle accident. He sought treatment for his injuries. An evaluation was performed and an aggressive treatment program was begun. He received essentially passive therapy for three months before progressing to active therapy. He then received active therapy for over eight months before beginning a work hardening program.

Requested Service(s)

Therapeutic exercises (97110), manual therapy technique (97140), electrical stimulation (97032), office visits (99213-25), massage therapy (97124), and therapeutic activities (97530) provided from 11/03/2004 through 07/25/2005.

Decision

It is determined that the therapeutic exercises (97110) from 12/01/2004 thru 02/28/2005, manual therapy technique (97140) from 11/03/2004 thru 11/30/2004, electrical stimulation (97032), from 11/03/2004 thru 11/30/2004, office visits (99213-25) from 11/03/2004 thru 02/28/2005 and therapeutic activities (97530) from 12/01/2004 thru 02/28/2005 were medically necessary to treat this patient's condition.

It is determined that the therapeutic exercises (97110) from 11/03/2004 to 12/01/2004 and 02/29/2005 thru 07/25/2005, manual therapy technique (97140) from 11/30/2004 thru 07/25/2005, electrical stimulation (97032), from 11/30/2004 thru 07/25/2005, office visits (99213-25) from 02/29/2005 thru 07/25/2005, massage therapy (97124) 11/03/2004 through 07/25/2005 and therapeutic activities (97530) from 02/29/2005 thru 07/25/2005 were not medically necessary.

Rationale/Basis for Decision

National treatment guidelines allow for this type of treatment for these types of injuries, however, not at the frequency and duration that this patient received. There is diagnostic testing to confirm a disc injury and not a simple strain. Electrodiagnostic testing was inconclusive due to the patient's history of diabetes. Manual therapy technique (97140) and massage therapy (97124) have similar therapeutic benefit and are essentially duplicated services when rendered on the same day. The office visits (99213-25) are allowed in order for the treating doctor to case manage this injured worker to document his status while either referrals are made, additional diagnostic testing is ordered or additional treatment is being rendered. However, it is not usual for this code to be utilized on every date of visit. Normally once per week is accepted as medically necessary. Therapeutic exercises and therapeutic activities are an important part of an active therapy program. However, in this case they are excessive.

Three months of active services from 12/01/2004 through 02/28/2005 to include one office visit (99213-25) per week as well as therapeutic exercises (97110) and therapeutic activities (97530) were medically necessary. There is sufficient clinical documentation to justify these services. Other services during that time frame as well as services from 03/01/2005 thru 07/25/2005 were not medically necessary.

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,

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