



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:
SCD Back and Joint Clinic, Ltd.
200 E. 24th Street, Suite B
Bryan, Texas 77803

MDR Tracking No.: M5-06-0539-01 / M5-05-2143-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:
Pacific Employers Insurance Company
Box 15

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: Per the table of disputed services "reasonable & necessary"

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent did not submit a response

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
10-03-02 to 11-07-02 (except for DOS 10-04-02, 10-18-02 and 10-31-02)	97150 (1 unit), 97110 (1 unit) and 97265 (1 unit)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$945.00
10-10-02	95851 (3 units) Note: Although the IRO found the services to be medically necessary per the 2002 MFG code 95851 is a component procedure of code 99214 billed on the same date of service. There are no circumstances in which a modifier would be appropriate. The services represented by the code combination will not be paid separately.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$0.00
10-03-02 to 02-24-03	99213, 97150, 97110, 97250, 97265, 99070, 97024, 95851, 97750-MT and 99080 (with the exceptions above)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
		Total	\$945.00

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.

Date of service 10-01-02 was not timely filed per Rule 133.308(e)(1) and will not be a part of the review.

On 12-16-05, 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 99080-73 dates of service 10-10-02 and 12-26-02 denied with denial code "V" (unnecessary treatment with peer review). The IRO reviewer determined that the office visit billed on the same date of service was not medically necessary. Per Rule 133.308(p)(5) an IRO decision is deemed to be a commission decision and order. Based on the IRO determination and Rule 133.308(p)(5) no reimbursement is recommended.

Review of CPT code 99213 dates of service 11-07-02, 11-08-02, 11-11-02, 11-18-02, 11-20-02, 11-22-02, 11-25-02, 11-27-02, 12-03-02, 12-04-02, 02-03-03, 02-05-03, 02-10-03 and 03-06-03 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for EOBs. Reimbursement is recommended in the amount of **\$672.00 (\$48.00 X 14 DOS)**.

Review of CPT code 97150 dates of service 11-07-02, 11-08-02, 11-11-02, 11-18-02, 11-20-02, 11-25-02, 12-03-02, 12-04-02, 02-03-03, 02-05-03 and 02-10-03 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for EOBs. Reimbursement is recommended in the amount of **\$297.00 (\$27.00 X 11 DOS)**.

Review of CPT code 97110 (68 units total) dates of service 11-07-02, 11-08-02, 11-11-02, 11-18-02, 11-20-02, 11-22-02, 11-25-02, 11-27-02, 12-03-02, 12-04-02, 02-03-03, 02-05-03 and 02-10-03 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for EOBs. 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". Therefore, 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 Commission requirements for proper documentation. The requestor did not submit documentation for review, therefore, no reimbursement is recommended.

Review of CPT code 97250 dates of service 11-07-02, 11-08-02, 11-11-02, 11-18-02, 11-20-02, 11-25-02, 11-27-02, 12-04-03, 02-03-03, 02-05-03 and 02-10-03 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for EOBs. Reimbursement is recommended in the amount of **\$473.00 (\$43.00 X 11 DOS)**.

Review of CPT code 97265 dates of service 11-07-02, 11-08-02, 11-11-02, 11-18-02, 11-20-02, 11-25-02, 11-27-02, 12-04-03, 02-03-03, 02-05-03 and 02-10-03 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for EOBs. Reimbursement is recommended in the amount of **\$473.00 (\$43.00 X 11 DOS)**.

Review of CPT code 99214 date of service 11-13-02 revealed that neither party submitted a copy of the EOB. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the request for an EOB. Reimbursement is recommended in the amount of **\$71.00**.

Review of CPT code 95951 (3 units each date of service) dates of service 11-13-02 and 03-04-03 revealed that neither party

submitted a copy of the EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the request for EOBs. Reimbursement is recommended in the amount of **\$216.00 (\$36.00 X 6 units)**.

Review of CPT code 99080-73 dates of service 11-13-02 and 03-04-03 revealed that neither party submitted a copy of the EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the request for EOBs. Reimbursement is recommended in the amount of **\$30.00 (\$15.00 X 2 DOS)**.

Review of CPT code 97014 dates of service 11-22-02, 11-27-02 and 12-03-02 revealed that neither party submitted a copy of the EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the request for EOBs. Reimbursement is recommended in the amount of **\$45.00 (\$15.00 X 3 DOS)**.

Review of CPT code 99070 date of service 11-22-02 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the request for an EOB. Reimbursement is recommended in the amount of **\$8.00**.

Review of CPT code 97750-MT date of service 02-07-03 (4 units), 03-04-03 (1 unit), 03-06-03 (2 units) and 03-10-03 (2 units) revealed that neither party submitted a copy of the EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the request for EOBs. Reimbursement is recommended in the amount of **\$387.00 (\$43.00 X 9 units)**.

Review of CPT code 99215 date of service 03-04-03 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the request for an EOB. Reimbursement is recommended in the amount of **\$103.00**.

CPT code 99213 dates of service 03-12-03, 03-17-03, 03-20-03, 03-21-03, 03-24-03 and 03-26-03 denied with denial code "R" (services do not appear related to work injury/diagnosis). A Benefit Dispute Agreement on 12-29-04 resolved the compensability or extent issue. Reimbursement is recommended in the amount of **\$288.00 (\$48.00 X 6 DOS)**.

CPT code 97110 dates of service 03-12-03, 03-17-03, 03-20-03, 03-21-03 and 03-24-03 denied with denial code "R" (services do not appear related to work injury/diagnosis). A Benefit Dispute Agreement on 12-29-04 resolved the compensability or extent issue. 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". Therefore, 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 Commission requirements for proper documentation. The requestor did not submit documentation for review, therefore, no reimbursement is recommended.

CPT code 97150 dates of service 03-12-03, 03-17-03, 03-20-03, 03-21-03 and 03-24-03 denied with denial code "R" (services do not appear related to work injury/diagnosis). A Benefit Dispute Agreement on 12-29-04 resolved the compensability or extent issue. Reimbursement is recommended in the amount of **\$135.00 (\$27.00 X 5 DOS)**.

CPT code 97250 dates of service 03-12-03, 03-17-03, 03-20-03, 03-21-03 and 03-24-03 denied with denial code "R" (services do not appear related to work injury/diagnosis). A Benefit Dispute Agreement on 12-29-04 resolved the compensability or extent issue. Reimbursement is recommended in the amount of **\$215.00 (\$43.00 X 5 DOS)**.

CPT code 97265 dates of service 03-12-03, 03-17-03, 03-20-03, 03-21-03 and 03-24-03 denied with denial code "R" (services do not appear related to work injury/diagnosis). A Benefit Dispute Agreement on 12-29-04 resolved the compensability or extent issue. Reimbursement is recommended in the amount of **\$215.00 (\$43.00 X 5 DOS)**.

Review of CPT codes 97750-MT, 99213, 97110, 97150, 97250, 97265, 99080, 99214, 99080-73 and 95851 billed for date range 03-27-03 through 04-11-03 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the

requestor did not provide convincing evidence of carrier receipt of the providers request for EOBs. NOTE: The requestor submitted evidence of carrier receipt of a request for EOBs but that evidence submitted did not include these dates of service in dispute. No reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, Rules 133.308(e)(1), 133.308(p)(5) and 133.307(e)(2)(B)

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 additional reimbursement in the amount of \$4,573.00. 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:

01-03-06

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.

Envoy Medical Systems, LP

1726 Cricket Hollow

Austin, Texas 78758

Phone 512/248-9020

Fax 512/491-5145

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

October 5, 2005

Re: IRO Case # M5-06-0539-01 formerly M5-05-2143 -01 ___ amended 12/15/05

Texas Worker's Compensation Commission:

Envoy Medical Systems, LP (Envoy) has been certified as an independent review organization (IRO) by the Texas Department of Insurance and has been authorized to perform independent reviews of medical necessity for Texas Workers' Compensation cases). Texas HB. 2600, Rule 133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that cases be assigned to certified IROs, this case was assigned to Envoy for an independent review. Envoy has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, Envoy received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board certified in Physical Medicine and Rehabilitation, and who has met the requirements for the Workers' Compensation Approved Doctor List or who has been granted an exception from the ADL. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and the injured employee, the injured employee's employer, the insurance carrier, the utilization review agent, any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to Envoy for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the Envoy reviewer who reviewed this case, based on the medical records provided, is as follows:

Medical Information Reviewed

1. Table of disputed services
2. DDE 10/8/02
3. Operative report 4/30/03
4. Neurologic consult report 9/23/02, Dr. Light
5. Clinical notes, Dr. Seabolt
6. Case review 9/30/02, Dr. Fahey
7. Initial assessment 9/11/02, Initial medical narrative 9/9/02 Dr. Bailey
8. Outpatient progress notes, Dr. Cowley
9. Right wrist, right shoulder, right elbow ROM reports 9/9/02
10. Chiropractic medical records 9/9/02 - 9/9/03, Dr. Bailey and Dr. Wyatt
11. Physical therapy medical records 9/18/02 - 11/20/03
12. Chiropractic office visit reports 9/9/02 - 7/8/05
13. Follow up notes 9/19/02 - 6/11/03, Dr. Seabolt
14. Operative report 4/30/03, Dr. Seabolt
15. CT scan right elbow 3/13/03
16. Electrodiagnostic evaluation 3/10/04
17. Follow up notes, Stonecipher
18. Initial evaluation 3/21/05 and report 4/25/05, Dr. Mahendru
19. Initial evaluation 7/12/05, Dr. Shanti
20. Evaluation 5/2/02, Dr. Nelson
21. X-ray reports right elbow, forearm, wrist, hand 5/8/02
22. Clinical note 3/5/02, Dr. Gaines
23. Clinical note 5/7/02, Dr. Spaw
24. Operative report 5/7/02, Dr. Spaw
25. Follow up notes, Dr. Spaw
26. X-ray reports right elbow 5/21/02, 6/1/02
27. Physical therapy records 2002
28. IME/IR reports 10/8/02, 1/28/03, 4/22/03 Dr. Huggins
29. DDE report 6/26/03, Dr. Dozier

History

The patient is a 36-year-old male who injured his right arm in _____. He continued to work and did not begin treatment until one month later. The patient was found on x-rays to have a right radial head fracture. He was referred to an orthopedist and underwent right radial head replacement on 5/7/02. He began post surgical rehabilitation on 5/22/02. Post-operative therapy continued through August 2002. In September 2002 the patient changed his treating doctor and his orthopedic surgeon. A 9/23/02 EMG/NCS was normal. The patient continued to have pain in the elbow and limited range of motion. A 10/8/02 DDE found limited flexion in the right elbow, and recommended four additional weeks of active therapy. The patient was not deemed to be at MMI at the time.

Requested Service(s)

Office visits 99213, group therapeutic procedures 97150, therapeutic exercises 97110, myofascial release 97250, joint mobilization 97265, supplies 99070, diathermy 97024, ROM 99080, 97750-MT
10/3/02 – 2/24/03

Decision

I agree in part and disagree in part with the carrier's decision to deny the requested services.

Rationale

I disagree with the denial of one unit each of 97150, 97110 and 97265 per therapy session between 10/3/02 and 11/7/02 (except for service on 10/4/02, 10/18/02, and 10/31/02), and ROM testing on 10/10/02. The patient severely injured his elbow when he fell on his outstretched hand. He suffered a fracture of the radial head that went untreated for a month. He then required replacement of the radial head. The patient had post-operative physical therapy, but he continued to have pain and severely limited range of motion. A DDE on 10/8/02 recommended four more weeks of physical therapy at that time. ROM testing was also necessary to evaluate the patient's deficits and monitor progress.

I agree with the denial of the remainder of the requested services.

Office visits for evaluation and management at the time of physical therapy is not appropriate or medically necessary.

The medical necessity of prescribed analgesic balm rather than OTC cream or balm is not documented.

Physical therapy services should be no more than 45 minutes per session on non-consecutive days. Some of the services between 10/3/02 and 11/7/02 represent either more than 45 minutes of services per session or occurred on consecutive days.

After 11/7/02 the patient could have continued exercises on his own with a home exercise program to further improve range of motion. The records provided do not document a need for continued supervised one on one therapy beyond 11/7/02. The patient had surgery on 5/7/02 and had had six months of physical therapy by this time. At that point he should have been able to continue exercises on his own.

This medical necessity decision by an Independent Review Organization is deemed to be a Workers' Compensation Division decision and order.

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 a 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 the 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 must be received by the Division of Workers' Compensation, chief Clerk of Proceedings, within then (10) days of your receipt of this decision.

Sincerely,

Daniel Y. Chin, for GP