



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

<b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address: Dr. Patrick R.E. Davis 115 W. Wheatland Road Ste 101 Duncanville, Texas 75116	MDR Tracking No.: M5-06-0628-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Twin City Fire Insurance Company Box 27	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 table of disputed services "Documentation supports medical necessity".

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

No response submitted by Respondent

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
01-31-05 to 04-22-05	97112-59 (1 unit @ \$35.66* X 18 units) = \$641.88 97110-59 (1 unit @ \$34.93 X 55 units) = \$1,921.15 97140-59 (1 unit @ \$32.90* X 8 units) = \$263.20 97140-59 (1 unit @ \$33.04 X 16 units) = \$528.64 99215-25 (\$147.68* X 2 DOS) = \$295.36 **E1399-NU (\$16.00 X 6 DOS) = \$96.00 98943-25 (1 unit @ \$30.12 X 5 units) = \$150.60 98943-25 (1 unit @ \$30.65 X 10 units) = \$306.50 97032-59 (1 unit @ \$19.46* X 4 units) = \$77.84 97035-59 (1 unit @ \$15.11 X 2 units) = \$30.22 97530-59 (1 unit @ \$36.78 X 76 units) = \$2,795.28 E0745-RR = \$111.89	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$7,218.56
	Note: * Less than MAR ** Rule 133.1(a)(3)(C) states that a complete medical bill includes correct billing codes from Division fee guidelines in effect on the date of service. The requestor will be billed for not following Rule 133.1(a)(3)(C)		

**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 **prevailed** on 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.

On 01-18-2006, 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 99215-25 date of service 01-31-05 was denied by the carrier with denial code "F" (reimbursement is being withheld as this procedure is considered integral to the primary procedure billed). Per the 2002 Medical Fee Guideline CPT code 99215 is a component procedure of code 98943 billed on date of service 01-31-05. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be considered justifiable if a modifier is used appropriately. Modifier 25 is an appropriate modifier. Reimbursement is recommended in the amount billed by the requestor of **\$147.68**.

CPT code 97140-59 dates of service 01-31-05 (1 unit), 02-04-05 (1unit), 02-07-05 (1 unit), 02-08-05 (2 units), 02-09-05 (1 unit), 02-21-05 (1 unit), 02-23-05 (2 units) and 02-25-05 (2 units) denied with either denial codes "F" (reimbursement is being withheld as this procedure is considered integral to the primary procedure billed) or "97" (payment is included in the allowance for another service/procedure. Included in global reimbursement. Reimbursement is being withheld as this procedure is considered integral to the primary procedure billed). Per the 2002 Medical Fee Guideline CPT code 97140-59 is not global to any other services billed on the dates of service in dispute. Reimbursement is recommended in the amount of **\$361.90 (\$32.90 X 11 units)**.

Review of CPT code 99080-73 date of service 02-02-05 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) there is no convincing evidence of carrier receipt of the providers request for an EOB. In addition, per Rule 133.307(e)(2)(A) the requestor did not submit a copy of the CMS 1500 for review. No reimbursement is recommended.

HCPCS code E1399-NU date of service 02-21-05 was denied by the carrier with denial code "D20" (claim/service missing service POD info. Please submit the appropriate Health Care Financing Administration Coding System (HCPCS) code for the listed services). Per the 2005 DMEPOS Fee Schedule this is not a valid HCPCS code. No reimbursement recommended.

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

28 Texas Administrative Code Sec. 133.308, 134.202(c)(1), 133.307(e)(2)(A) and (B) and 133.1(a)(3)(C)

**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 reimbursement in the amount of \$7,728.14. In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee (\$460.00). 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:

03-06-06

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date of Findings and Decision

Order by:

03-06-06

\_\_\_\_\_  
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.**

February 27, 2006

**ATTN: Program Administrator**  
**Texas Department of Insurance/Workers Compensation Division**  
7551 Metro Center Drive, Suite 100  
Austin, TX 78744  
Delivered by fax: 512.804.4868

### Notice of Determination

MDR TRACKING NUMBER: M5-06-0628-01  
RE: Independent review for \_\_\_\_

The independent review for the patient named above has been completed.

- Parker Healthcare Management received notification of independent review by UPS on 1.19.06.
- Faxed request for provider records made on 1.19.06.
- TDI DWC issued an Order for payment on 1.30.06.
- The case was assigned to a reviewer on 2.6.06.
- The reviewer rendered a determination on 2.24.06.
- The Notice of Determination was sent on 2.27.06.

The findings of the independent review are as follows:

#### Questions for Review

The therapy in question consists of neuromuscular re-education (97112-59), therapeutic exercise (97110-59), chiropractic manipulation (98943-25), manual therapy technique (97140-59), electrical stimulation (97032-59), ultrasound (97035-59), therapeutic activities (97530-59), E1399-NU (Tens pads), Office visits (99215) and E0745-RR. The dates in dispute are listed from 1.31.05 to 4.22.05.

#### Determination

PHMO, Inc. has performed an independent review of the proposed care to determine if the adverse determination was appropriate. After review of all medical records received from both parties involved, the PHMO, Inc. physician reviewer has determined to **overturn the denial** on all of the disputed service(s).

#### Summary of Clinical History

The claimant is apparently suffering from right wrist complaints and is post operative for CTR release on 1.6.05. The therapy in question for the work related injury is apparently services that were done post-surgically for the injured wrist.

#### Clinical Rationale

The patient demonstrated very clear objective improvement from the aforementioned approved therapy. Over the documented course and duration of the disputed therapy, the patient had a significant increase in right hand and wrist strength, increased range of motion and clinical findings such as sensation and motor responses improved. The orthopedic evaluation also demonstrated less pain and discomfort during various related orthopedic tests. The patient improved in virtually every area clinically, including both

subjective and objective categories. Therapy was administered until function was restored. The improvement was constant and consistent throughout the duration of the care in dispute. The documentation then reveals that the patient was appropriately discharged from post-surgical care due to noted improvement. The patient did fall outside of the typical “guidelines” for recovery for the given injury. This is, however, acceptable because the patient continued to demonstrate improvement that was significant and steady and demonstrated a curative effect from the administered therapy until they reached acceptable function, thus making care acceptable, regardless of guideline application or interpretation.

Clinical Criteria, Utilization Guidelines or other material referenced

- *Occupational Medicine Practice Guidelines*, Second Edition.
- *The Medical Disability Advisor*, Presley Reed MD
- *A Doctors Guide to Record Keeping*, Utilization M

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The reviewer for this case is a doctor of chiropractic peer matched with the provider that rendered the care in dispute. The reviewer is engaged in the practice of chiropractic on a full-time basis.

The review was performed in accordance with Texas Insurance Code 21.58C and the rules of Texas Department of Insurance /Division of Workers' Compensation. In accordance with the act and the rules, the review is listed on the DWC's list of approved providers or has a temporary exemption. The review includes the determination and the clinical rationale to support the determination. Specific utilization review criteria or other treatment guidelines used in this review are referenced.

The reviewer signed a certification attesting that no known conflicts-of-interest exist between the reviewer and the treating and/or referring 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.

The reviewer also attests that the review was performed without any bias for or against the patient, carrier, or other parties associated with this case.

#### 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. The address for the Chief Clerk of Proceedings would be: P.O. Box 17787, Austin, Texas, 78744.

I hereby verify that a copy of this Findings and Decision was faxed to Texas Department of Insurance /Division of Workers Compensation applicable to Commission Rule 102.5 this 27<sup>th</sup> day of February, 2006. The Division of Workers Compensation will forward the determination to all parties involved in the case including the requestor, respondent and the injured worker.

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Meredith Thomas  
Administrator  
Parker Healthcare Management Organization, Inc.