



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: Laurence N. Smith, D.C. P O BOX 551413 Dallas, Texas 75355-1413	MDR Tracking No.: M5-06-0684-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: 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

DOCUMENTATION SUBMITTED: DWC-60 dispute package
 POSITION SUMMARY: According to V.T.C.A. 408.021, "an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that : (1) cures or relieves the effects naturally resulting from the compensable injury, (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment....."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60
 POSITION SUMMARY: "Texas Mutual requests that the request for dispute resolution filed by DR LAWRENCE SMITH DC, be conducted under the provisions of the APA set out above."

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
10-01-04 to 01-27-05	97110 (3 units @ \$108.39 X 10 DOS = \$1,083.90)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$3,255.42
	97110 (1 unit @ \$33.55 X 2 DOS = \$67.10)		
	97110 (1 unit @ \$39.47 X 1 DOS = \$36.99 (MAR))		
	97110 (2 units @ \$71.18 X 1 DOS = \$71.18)		
	97110 (1 unit @ \$34.31 X 1 DOS = \$34.31)		
	97110 (1 unit @ \$36.11 X 1 DOS = \$36.11)		
	97110 (1 unit @ \$37.77 X 1 DOS = \$36.14 (MAR))		
	97110 (4 units @ \$144.52 X 2 DOS = \$289.04)		
	97140-59 (2 units @ \$68.33 X 3 DOS) = \$204.78 (MAR))		
	99213 (\$68.31 X 2 DOS = \$136.48 (MAR))		
	97530 (1 unit @ \$38.00 X 3 DOS = \$112.74 (MAR))		
	97112 (3 units @ \$111.15 X 8 DOS = \$889.20)		
	97112 (1 unit @ \$35.15 X 1 DOS = \$35.15)		
97112 (1 unit @ \$37.05 X 6 DOS = \$222.30)			
10-01-04 to 07-13-05	97032	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
02-01-05 to 07-13-05	98941, 97112, 97530, 99213, 97140-59, 97110 and 99214	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00

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.

On 12-22-05, 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 date of service 10-01-04 was denied with denial codes "287/864" (service is denied because the doctor is not on the Texas Approved Doctors list (ADL) for this date of service/E-M services may be reported only if the patient's condition requires a significant separately identifiable E-M service). Per the 2002 Medical Fee Guideline the provider can bill code 99213 with modifier 25 for separate payment. The provider did not bill with the 25 modifier. No reimbursement recommended. The provider was on the ADL at the time the service was rendered.

CPT code 99080 date of service 11-05-04 was denied with denial code "G" (unbundling). Per the 2002 Medical Fee Guideline code 99080 is not global as there were no other services billed on this date of service. Per Rule 133.307(g)(3)(A-F) the requestor did not submit documentation for review. No reimbursement recommended.

CPT code 99213 dates of service 12-02-04, 12-28-04, 01-26-05 and 01-27-05 were denied by the carrier with denial codes "F/790" (Fee Guideline MAR reduction/this charge was reduced in accordance to the Texas Medical Fee Guideline). Payment totaling \$262.25 has been made by the carrier. Additional reimbursement in the amount of **\$10.85 (MAR of \$68.24 X 2 plus MAR of \$68.31 X 2 = \$273.10 minus carrier payment)** is recommended.

CPT code 97140-59 dates of service 12-02-04 (2 units), 01-25-05 (2 units), 01-26-05 (2 units) and 01-27-05 (2 units) were denied with denial codes "F/790" (Fee Guideline MAR reduction/this charge was reduced in accordance to the Texas Medical Fee Guideline). Payment in the amount of \$263.86 has been made by the carrier. Additional payment in the amount of **\$9.36 (MAR of \$273.22 minus carrier payment)** is recommended.

CPT code 97530 dates of service 12-02-04 and 01-25-05 were denied with denial codes "F/790" (Fee Guideline MAR reduction/this charge was reduced in accordance to the Texas Medical Fee Guideline). Payment in the amount of \$71.90 has been made by the carrier. Additional payment in the amount of **\$3.86 (MAR of \$75.76 minus carrier payment)** is recommended.

CPT code 98941 date of service 01-25-05 denied with denial codes "F/790" (Fee Guideline MAR reduction/this charge was reduced in accordance to the Texas Medical Fee Guideline). Payment in the amount of \$46.24 has been made by the carrier. Additional reimbursement in the amount of **\$0.97 (MAR \$47.21 minus carrier payment)** is recommended.

CPT code 99080 date of service 03-31-05 denied with denial codes "57/247/97" (payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage or this day's supply/evidence does not support the need for the duration, intensity and/or services billed/payment is included in the allowance for another service/procedure). Per the 2002 Medical Fee Guideline code 99080 is not global to other services billed on 03-31-05. Per Rule 133.307(g)(3)(A-F) the requestor did not submit documentation to review. No reimbursement is recommended.

28 Texas Administrative Code Sec. 133.308 and 134.202(c)(1)

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 \$3,280.46. 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.

Order by:

02-17-06

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.

Amended February 14, 2006

Amended February 15, 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: M5-06-0684-01

RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 12.22.05.
- Faxed request for provider records made on 12.22.05.
- TDI issued an Order for Records from respondent on 1.4.06.
- The case was assigned to a reviewer on 1.11.06.
- The reviewer rendered a determination on 1.26.06.
- The Notice of Determination was sent on 1.27.06.
- An amendment on the determination was done on 1.30.06.
- An amendment on the determination was done on 2.15.06.

The findings of the independent review are as follows:

Questions for Review

The therapies in dispute are listed as therapeutic exercise (97110), manual therapy (97140-59), electrical stimulation (97032), office visit (99213/99214), chiropractic manipulation (98941), therapeutic activities (97530) and neuromuscular reeducation (97112). The dates of service in question are listed from 10.1.04 until 7.13.05.

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 the denied services:

Therapeutic exercise (97110), manual therapy (97140-59), office visit (99213), therapeutic activities (97530) and neuromuscular reeducation (97112) that were rendered through date of service 1.27.05.

The PHMO, Inc. physician reviewer has also determined to **uphold the denial** on all of the denied service(s): electrical stimulation (97032) **and** any other disputed services {therapeutic exercise (97110), manual therapy (97140-59), office visit (99213/99214), chiropractic manipulation (98941), therapeutic activities (97530) and neuromuscular reeducation (97112)} rendered after date of service 1.27.05.

Summary of Clinical History

The claimant was injured as a result of a work related injury on _____. The neck and the lower back were the areas that are suffering as a result of the injury. Since the onset, the claimant has had various provider referrals, conservative care and surgical care. There have also been referrals for imaging and other diagnostics.

Clinical Rationale

Based upon the documentation, the claimant had significant symptoms and pain types that improved from therapy up until the date of February 17, 2005. After this there were no symptoms marked as being present in the "pain type" section of the doctor's notes, and after this point when there were symptoms marked, the VAS score was at or near 0. Having said this, it appears that therapy was beneficial for the claimant and he reached maximum therapeutic benefit on 2.17.05. This was near the anticipated date that the designated doctor anticipated for actual MMI. He anticipated a date of 1.23.05 for MMI. The electrical stimulation was performed way outside of the acute or subacute time frame of recovery, thus it should not be considered as a reasonable form of care during this time period.

Clinical Criteria, Utilization Guidelines or other material referenced

- *Occupational Medicine Practice Guidelines*, Second Edition.
- *The Medical Disability Advisor*, Presley Reed MD

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 27th day of January, 2006. An amendment was preformed on this determination the 15th 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.

Meredith Thomas
Administrator, Parker Healthcare Management Organization, Inc.