



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: Allied Multicare Centers 415 Lake Air Drive Waco, Texas 76710	MDR Tracking No.: M5-06-0883-01 Previous MDR Tracking No.: M5-06-0443-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: State Office of Risk Management, Box 45	Date of Injury: 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, "We are officially notifying the 'Commission' that the sender of this package is requesting a 'Medical Dispute Resolution by an Independent Review Organization' pursuant to Rule 133.308."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response. Position summary states, "For dates of service after 5-20-05 the treatment has exceeded Medicare's PM&R Guidelines. Documentation does not substantiate necessity."

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)
11-15-04 – 6-12-05	CPT code 97110 (\$33.56 X 66 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2,214.96
11-15-04 – 6-12-05	CPT code 97112 (\$34.30 X 3 units – 2 units not payable, see below)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$102.90
11-15-04 – 6-12-05	CPT code 97530 (\$34.65 X 84 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2,910.60
11-15-04 – 6-12-05	CPT code 97124 - not payable, see below)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	0
11-15-04 – 6-12-05	CPT code 98940 (\$31.35 X 2 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$62.70
11-15-04 – 6-12-05	CPT code 98943 - DOP code – 11 units (see below)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	0
6-14-05	CPT code 95831	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
2-14-05 – 6-7-05	CPT code 99212 (\$44.16 X 4 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$176.64
12-9-04 – 2-13-05	CPT codes 97110, 97530, 97124, 98940 (none reported)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
6-13-05 – 8-19-05	CPT codes 97110, 97530, 97124, 98940, 98943, 95831, 99212	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
Total			\$5,467.80

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.

CPT codes 97112 and 97124 were determined to be medically necessary by the IRO. However, these services are considered by Medicare to be component procedures of CPT code 98940 or 98943 which were billed on some dates of service. 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. A modifier was not used correctly to differentiate the services on some dates of service. The services represented by the code combination will not be paid separately.

The Division has reviewed the enclosed IRO decision and determined that the requestor did prevail on the majority of the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$5,467.80.

Regarding CPT code 98943: Texas Labor Code 413.011 (d) and Rule 133.304 (i) (1-4) place certain requirements on the Carrier when reducing the services for which the Division has not established a maximum allowable reimbursement. The Carrier is required to develop and consistently apply a methodology to determine fair and reasonable reimbursement and explain and document the method used for the calculation. The Carrier in this case has not provided a methodology as required by the rule. Therefore, the MAR for CPT code 98943 is the amount assigned by the carrier that is consistent with the requirements of this rule.

On 3-15-06 the requestor forwarded a revised Table of Disputed Services withdrawing services which had been reimbursed by the carrier. This revised Table was used for this review.

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 1-23-06 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 97112-GP on 11-17-04, 12-3-04, 2-28-05, 3-14-05, 3-28-05, 4-4-05, 4-6-05, 4-8-05, 4-11-05, 4-13-05, 4-15-05, 4-18-05, 4-20-05, 4-22-05, 4-25-05, 4-27-05, 4-29-05, 5-2-05, 5-5-05, 5-6-05 and 5-11-05 was denied by the carrier as "97-charge included in another charge or service" or as "R38-included in another procedure." CPT code 97112 is considered by Medicare to be a component procedure of CPT code 98940 or 98943 which was billed on these dates of service. 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. A modifier was not used correctly to differentiate the services. The services represented by the code combination will not be paid separately.

One unit of CPT code 97110 on 2-25-05, 2-28-05, 3-3-05, 3-4-05, 3-10-05, 3-14-05, 3-18-05, 3-28-05, 4-4-05, 4-6-05 and 4-11-05 was denied by the carrier as "W1-Worker's Compensation State Fee Schedule." The MRD will order payment because the SOAP notes do clearly delineate exclusive one-on-one treatment and the requestor did identify the severity of the injury to warrant exclusive one-to-one therapy. Recommend additional payment of \$379.06.

CPT code 97124-GP on 3-14-05, 4-4-05, 4-6-05, 4-13-05, 4-22-05, 4-27-05, 5-2-05, 5-11-05, 6-3-05, 6-27-05 and 7-6-05 was denied by the carrier as "97-charge included in another charge or service" or as "R38-included in another procedure." CPT code 97124 is considered by Medicare to be a component procedure of CPT code 98940 or 98943 which was billed on these dates of service. 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. A modifier was not used correctly to differentiate the services. The services represented by the code combination will not be paid separately.

CPT code 97530 on 3-16-05, 3-18-05 (3 units), 3-21-05, 4-6-05 (3 units), 4-8-05 (3 units) and 4-11-05 (3 units) was denied by the carrier as "119-Benefit maximum has been reached" or as "W1-Worker's Compensation State Fee Schedule." The carrier made no payment and gave no valid reason for not doing so. Recommend reimbursement per Rule 134.202(c)(1) of \$485.10 (\$34.65 X 14 units).

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 entitled to a refund of the paid IRO fee (\$460.00). The Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute in the amount of \$6,331.96 plus DOP amount. 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

5-17-06

Margaret Ojeda

5-17-06

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.