



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:	MDR Tracking No.: M5-06-1023-01
Health and Medical Practice Associates 324 N. 23 <sup>rd</sup> St. Ste. 201 Beaumont, TX 77707	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:
TX Mutual Insurance Company, Box 54	

#### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 package. The requestor stated that he disagreed with the respondent's denial which stated that there was no adequate documentation. The requestor stated, "We feel certain that, after you review this, we will be paid accordingly."

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

Documents include the DWC 60 response. Position summary states, "Texas Mutual requests that the request for dispute resolution filed be conducted under the provisions of the APA set out above."

#### 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)
2-24-04 - 8-3-05	CPT codes 97032, 97012, 97124 and 97530	<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.

The Division has reviewed the enclosed IRO decision and determined that the requestor did not prevail on the disputed medical necessity issues.

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 4-4-06 the requestor sent a revised Table of Disputed Services. The requestor withdrew those services which had been correctly paid per the contract.

On 2-23-06 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.

The carrier denied CPT code 97140-GP on 2-24-05 with "434 - The value of the procedure is included in the value of the mutual exclusive procedure" and "97 - Payment is included in the allowance for another procedure." According to the 2002 MFG "this procedure is considered by Medicare to be a mutually exclusive procedure of CPT code 97012. A modifier is allowed in order to differentiate between the services provided." "GP-Services delivered under an outpatient physical therapy plan of care" is not an acceptable modifier. Recommend no reimbursement.

The carrier denied CPT code 95900-59 on 8-3-05 with "435 - The value of the procedure is included in the value of the comprehensive procedure" and "97 - Payment is included in the allowance for another procedure." According to the 2002 MFG "This procedure is considered by Medicare to be a component procedure of CPT code 95903. A modifier is allowed in order to differentiate between the services provided." The requestor did use the "59" modifier, however, there were no office notes to support delivery of services per Rule 133.307(g)(3)(A-F). Recommend no reimbursement.

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

28 Texas Administrative Code Sec. 133.307(g)(3)(A-F), 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 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

4-5-06

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

March 22, 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 #: M5-06-1023-01  
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 §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 TMF physician reviewer who is board certified in Family Practice which is the same specialty as the treating physician, provides health care to injured workers, and licensed by the Texas State Board of Medical Examiners in 1979. 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 on \_\_\_ when he was lifting a battery from a storage shelf and slipped while placing it on a dolly. The patient complains of lower back pain and stiffness and has been treated with physical therapy treatment.

### Requested Service(s)

Electrical stimulation (97032), mechanical traction (97012), message therapy (97124) and therapeutic activities (97530) provided from 02/24/2005 to 08/03/2005

### **Decision**

It is determined that the electrical stimulation (97032), mechanical traction (97012), message therapy (97124) and therapeutic activities (97530) provided from 02/24/2005 to 08/03/2005 were not medically necessary to treat this patient's condition.

### Rationale/Basis for Decision

The medical record documentation indicates that the initial report dated 02/22/2005 and supplemental reports dated 05/04/2005 and 06/01/2005 have physical examination findings specifically of the lumbar region that indicate the treatment modalities were not improving the patient's condition. However, the recommendations/treatment plan was for the same

modalities of electrical stimulation, mechanical traction, therapeutic procedure and myofacial release to the lumbar region. If the recommended treatment has not had a significant impact on the patient's condition in a reasonable period of time, there is no indication to continue the same modality of treatment.

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,

A handwritten signature in black ink that reads "Gordon B. Strom, Jr." in a cursive, slightly slanted script.

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

GBS:dm

Attachment

Information Submitted to TMF for Review

Patient Name:

Tracking #: M5-06-1023-01

**Information Submitted by Requestor:**

- Letter to the IRO
- Report of MRI of the lumbar spine
- Nerve conduction study
- Coverage policy
- Medical Fee Guidelines
- Initial Reports
- Supplemental Reports
- Daily notes reports
- Medical Progress Notes
- Workers' Compensation Prescriptions
- Physical exams and objective spinal findings
- Insurance claim forms
- Explanation of Benefits

**Information Submitted by Respondent:**

None