



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.: M5-06-1060-01 |
| Valley Spine Medical Center<br>5327 South McColl Rd.<br>Edinburg, Texas 78539                 | 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. Position summary states, "Medical necessity was established in the patient's clinical notation."

#### 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) |
|--------------------|-----------------------------------|---|--------------------------------|
| 5-25-05 – 7-21-05  | CPT code 97035 (\$14.63 X 24 DOS) | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$351.12                       |
| 5-25-05 – 7-21-05  | CPT code 97124 (\$26.63 X 2 DOS)  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$53.26                        |
| 5-25-05 – 7-21-05  | CPT code 97110 (\$33.56 X 81 DOS) | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$2,718.36                     |
| 5-25-05 – 7-21-05  | CPT code 97140 (\$31.79 X 3 DOS)  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$95.37                        |
| 5-25-05 – 7-21-05  | CPT code 99212 (\$45.26 X 2 DOS)  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$90.52                        |
| Grand Total        |                                   |   | \$3,308.63                     |

#### 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 prevail on the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$3,308.63.

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 2-27-06 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 on all dates of service after 5-26-05 as "434 - the value of the procedure is included in the value of the mutually exclusive procedure." According to the 2002 MFG this procedure is considered by Medicare to be a mutually exclusive procedure of CPT code 97012 which was also billed on these dates of service. A modifier is allowed in order to differentiate between the services provides. Per the CMS-1500's no modifier was billed on these services. Recommend no reimbursement.

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

28 Texas Administrative Code Sec. 133.308 and Rule 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 carrier must refund the amount of the IRO fee (\$460.00) to the requestor within 30 days of receipt of this order. The Division has determined that the requestor is entitled to reimbursement in the amount of \$3,308.63. 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

4-4-06

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 #: M5-06-1060-01  
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 Rule §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 matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. 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 carrying a large container of raw meat and slipped and lost his balance. This resulted in injury to his lower back as well as his right shoulder, right side of his neck, and mid back. A portion of the patient's treatment has been chiropractic care.

### Requested Service(s)

(97035) ultrasound, (97124) massage, (97110) therapeutic exercises, (97140) manual therapy technique, (99212) office visits provided from 05/25/2005 through 07/21/2005

### **Decision**

It is determined that the (97035) ultrasound, (97110) therapeutic exercises, (97140) manual therapy technique, and the (99212) office visits provided from 05/25/2005 through 07/21/2005 were medically necessary to treat this patient's condition.

It is determined that the (97124) massage provided from 05/25/2005 through 07/21/2005 was not medically necessary to treat this patient's condition.

#### Rationale/Basis for Decision

The medical records in this case adequately documented that a compensable injury occurred on 05/19/2005 and that the patient injured his cervical, thoracic and lumbar spinal areas, as well as his right shoulder. The number of involved areas supports the medical necessity for the additional disputed services and units having been performed, but additionally, the *Guidelines for Chiropractic Quality Assurance and Practice Parameters*<sup>1</sup> supports an 8-week trial of manual therapy. These services fall within this designated time frame.

However, despite the subtle inherent differences described in CPT2 between myofascial release and massage therapy, there is still clear overlap in these procedures, and the documentation submitted failed to support the medical necessity for performing both on the same patient encounter.

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,



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

GBS:dm

Attachment

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<sup>1</sup> Halderman, S; Chapman-Smith D; Petersen, D *Guidelines for Chiropractic Quality Assurance and Practice Parameters*, Aspen Publisher, Inc.

<sup>2</sup> CPT 2004: *Physician's Current Procedural Terminology, Fourth Edition, Revised*. (American Medical Association, Chicago, IL 1999),

Information Submitted to TMF for Review

Patient Name:

Tracking #: M5-06-1060-01

**Information Submitted by Requestor:**

- Table of disputed services
- Requests for Reconsideration
- MRI reports of cervical and lumbosacral spine
- MRI report of right shoulder
- Initial Medical Narrative Reports
- Follow up evaluations
- Progress notes
- Therapeutic procedure charts
- Explanation of Benefits
- Insurance claims

**Information Submitted by Respondent:**

None