



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:  Neuromuscular Institute of Texas – P. A. 9502 Computer Drive, Suite 100 San Antonio, TX 78229	MDR Tracking No.: M5-06-1094-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  City of San Antonio, Box 42	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, "Treatment was provided within the scope of practice and billed as usual/customary charges."

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

Documents include the DWC 60 response.

#### 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)
3-14-05 – 10-14-05	CPT code 97110 (\$33.56 <MAR X 17 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$570.52
3-14-05 – 10-14-05	CPT code 97140-59 (\$31.79 X 2 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$63.58
	Total		\$634.10

#### 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 \$634.10.

On 4-7-06 the requestor withdrew CPT code 99212 on 2-23-05. This service will not be a part of 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 3-7-06 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.

Regarding CPT code 99080-73 on 2-18-05 and 2-23-05: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). The DWC 60 is a required report per 129.5. Review of the file shows that there was not significant change to warrant two 99080-73 reports within six days. Recommend reimbursement of \$15.00.

CPT code 99080-RR on 3-8-05 was denied by the carrier as "W1A-Workers compensation State Fee Schedule Adjustment." Per Rule 129.5 "CPT code '99080' with modifiers '73' and 'RR' (for 'requested report') shall be used when the doctor is billing for an additional report requested by or through the carrier under subsection (d)(3) of this section." Recommend reimbursement of \$14.50.

CPT code 99213 on 3-9-05 was denied by the carrier as "150-Payment adjusted because the payer deems the information submitted does not support this level of services." The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Recommend reimbursement of \$61.89.

CPT code 99080-73 on 3-9-05 was denied by the carrier as "D19G-Claim/Service lacks Physician/Operative or other supporting documentation." A review of the file indicates that this report has not been filed more often than necessary. The requestor provided the report to support delivery of services per Rule 133.307(g)(3)(A-F). Recommend reimbursement of \$15.00.

CPT code 97110 on 3-23-05 was denied by the carrier as "W3-Additional payment made on appeal." The EOB shows that the carrier did indeed reimburse the requestor for one unit of this service. However, the IRO decision indicates that two units per date of service are medically necessary. Per Rule 133.308 (p)(5) an IRO decision is deemed to be a Division decision and order. Recommend additional reimbursement of \$33.56.

CPT code 99213 on 5-5-05 was denied by the carrier as "97H-Payment is included in the allowance for another service/procedure." This service is not comprehensive to any other procedure performed on this date. Recommend reimbursement of \$61.89.

CPT code, 98940-GP on 10-3-05 and 10-14-05 was denied by the carrier as "131-Claim specific negotiated discount." The requestor states that there is no contract with this insurance company. The respondent was contacted numerous times but sent no response regarding a contract on this denial code. Recommend additional reimbursement per Rule 134.202(c)(1) of \$12.54.

CPT code 97012-GP on 10-14-05 was denied by the carrier as "131-Claim specific negotiated discount." The requestor states that there is no contract with this insurance company. The respondent was contacted numerous times but sent no response regarding a contract on this denial code. Recommend additional reimbursement per Rule 134.202(c)(1) of \$3.55.

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

28 Texas Administrative Code Sec. 133.307(e)(3)(B), 133.307(g)(3)(A-F), 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 \$852.03. 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, Medical Dispute Officer

5-11-06

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.**

March 31, 2006

Texas Department of Insurance Division of Texas Worker's Compensation  
MS48  
7551 Metro Center Drive, Suite 100  
Austin, Texas 78744-1609

### NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M5-06-1094-01  
DWC #:**

**Requestor: Neuromuscular Institute of Texas PA  
Respondent: City of San Antonio c/o Harris & Harris  
MAXIMUS Case #: TW06-0037**

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. The TDI, Division of Workers Compensation (DWC) has assigned this case to MAXIMUS in accordance with Rule §133.308, which allows for a dispute resolution by an IRO.

MAXIMUS has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the MAXIMUS external review panel who is familiar with the condition and treatment options at issue in this appeal. This case was also reviewed by a practicing physician on the MAXIMUS external review panel who is familiar with the condition and treatment options at issue in this appeal. This physician is board certified in neurosurgery. The reviewers have met the requirements for the approved doctor list (ADL) of DWC or have been approved as an exception to the ADL requirement. A certification was signed that the reviewing providers have no known conflicts of interest between that provider and 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, was signed. In addition, the MAXIMUS physician reviewers certified that the review was performed without bias for or against any party in this case.

#### **Clinical History**

This case concerns an adult female who sustained a work related injury on \_\_\_\_\_. The patient reported that while lifting a stretcher she had pain in the shoulder. She also reported that the pain went away but returned on 1/5/05 while lifting a large patient when she felt sharp pain and numbness into the digits of the left hand. Diagnoses included cervical sprain/strain and cervical intervertebral disc without myelopathy. Evaluation and treatment have included chiropractic treatment, osteopathic treatment and injections.

#### **Requested Services**

Additional unit of therapeutic exercise 97110 and manual therapy technique 97140-59 from 3/14/05 to 10/14/05.

#### **Documents and/or information used by the reviewer to reach a decision:**

##### *Documents Submitted by Requestor:*

1. Correspondence and Records from Neuromuscular Institute of Texas – 1/19/05-12/12/05
2. Physical Assessment of Duty Related Injury – 2/18/05, 2/23/05

*Documents Submitted by Respondent:*

1. Orthopedic Surgery Review of Records – 8/4/05
2. Determination Notices – 3/9/05

**Decision**

The Carrier's denial of authorization for the requested services is overturned.

**Standard of Review**

This MAXIMUS determination is based upon generally accepted standard and medical literature regarding the condition and services/supplies in the appeal.

**Rationale/Basis for Decision**

The MAXIMUS chiropractor consultant indicated that the records clearly report the amount of time and therapy performed for this patient. The MAXIMUS chiropractor consultant noted that the member had several sets of therapy sessions. The MAXIMUS chiropractor consultant explained the services in question are within the 10-12 weeks of medical necessity care for treatment of this patient's condition. The MAXIMUS chiropractor consultant also noted that these services were guiding the patient back through active rehabilitation and a second set of therapy was appropriate. The MAXIMUS chiropractor consultant indicated maximum medical improvement was not reached until 10/27/05, which was 7 months after this treatment took place.

Therefore, the MAXIMUS chiropractor consultant concluded that the therapeutic exercise 97110 and manual therapy technique 97140-59 from 3/14/05 to 10/14/05 were supported as medically necessary.

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Sincerely,  
**MAXIMUS**

Lisa Gebbie, MS, RN  
State Appeals Department