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

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier

Requestor's Name and Address: Central Dallas Rehab 3500 Oak Lawn, Suite 380 Dallas, TX 75219	MDR Tracking No.: M5-06-1108-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Fidelity First Insurance Company, Box 03	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 medically necessary."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC-60 response. Position Summary states, "Excessive PT was rendered."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Date of service 1-2-02 was withdrawn by the requestor and will not be a part of this review.

On 3-6-06 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 codes 97265, 97250, 97110 and 97122 for dates of service 1-7-02 through 5-31-02 were denied by the carrier as "T – Not according to Treatment Guidelines." Article 6 of House Bill 2600, adopted during the 77th Texas Legislative Session, 2001, states that treatment guidelines adopted under Chapter 413 of the Texas Labor Code are abolished on January 1, 2002. The review will be per the 96 MFG. Per I. A. 10. a. of the Medicine Ground Rules: "A physical medicine sessions is defined as any combination of four modalities (97010 – 97039), procedures and/or physical medicine activities and training (97220 – 97541). The maximum amount of time allowed per session is two hours."

The resubmission EOB's also showed an "additional denial code – U-Unnecessary medical treatment." Patient Office Visit Reports for these disputed dates of service document the injured worker's pain levels during the time of treatment. The Office Visit Report for date of service 1-7-02, which was the beginning date of disputed treatment, is somewhat confusing. This Report states, "The injured worker describes pain he is having in the region of the foot on the left. The pain scale number today was stated at a **6**. Swelling is reported by injured worker in the region(s) of the foot on the left. The pain scale number today was stated at a **6**. The injured worker has reduced motion in the area of the foot on the left. The pain scale number today was stated at a **7**. Soreness is a complaint made by the injured worker to the foot on the left. The pain scale number today was stated at a **7**."

The Office Visit Report for date of service 5-31-02, which was the ending date of disputed treatment, is almost identical to the notation for date of service 1-7-02, which was the beginning date of disputed treatment. This Report states, "The injured worker describes pain he is having in the region of the foot on the left. The pain scale number today was stated at a **5.** Swelling is reported by injured worker in the region(s) of the foot on the left. The pain scale number today was stated at a **6**. The injured worker has reduced motion in the area of the foot on the left. The pain scale number today was stated at a **5**. Soreness is a complaint made by the injured worker to the foot on the left. The pain scale number today was stated at a **7**.

No reimbursement recommended for CPT codes 97265, 97250, 97110 and 97122 for dates of service 1-7-02 through 5-31-02. The Office Visit Reports document little improvement for the approximately five months of treatment.

Regarding CPT code 97110 from 1-7-02 through 5-31-02 were denied by the carrier as "T – Not according to Treatment Guidelines" and as "additional denial code – U-Unnecessary medical treatment". Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Division has reviewed the matters in light all of the requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Reimbursement not recommended.

CPT codes 97750-MT for dates of service 1-7-02, 1-25-02, 4-16-02, 5-17-02 (one unit each date) was denied by the carrier as "T – Not according to Treatment Guidelines." The resubmission EOB's also showed an "additional denial code - U-Unnecessary medical treatment." Article 6 of House Bill 2600, adopted during the 77th Texas Legislative Session, 2001, states that treatment guidelines adopted under Chapter 413 of the Texas Labor Code are abolished on January 1, 2002. The review will be per the 96 MFG. Per the Medicine Ground Rules E. 3. , "Muscle Testing requires a report identifying the service provided, results, and interpretation of the test and shall be reimbursed per body area." No report was submitted to support services rendered. No reimbursement recommended.

CPT codes 97750 for date of service 5-31-02 was denied by the carrier as F- lasted 2 ¼ hour per your documentation." The review will be per the 96 MFG. The requestor billed $387.00 and the carrier has paid $225.00. Per the Medicine Ground Rules E. 2. a. "A summary report for each FCE is required and shall not be reimbursed in addition to the evaluation charge. Required documentation includes the start and end time for the FCE." No report was submitted to support services rendered. No reimbursement recommended.

CPT code 95851 for date of service 5-8-02 was denied by the carrier as "T – Not according to Treatment Guidelines." Article 6 of House Bill 2600, adopted during the 77th Texas Legislative Session, 2001, states that treatment guidelines adopted under Chapter 413 of the Texas Labor Code are abolished on January 1, 2002. The resubmission EOB's also showed an "additional denial code - U-Unnecessary medical treatment." The review will be per the 96 MFG. Per the MFG Medicine GR, ROM measurements are included in a re-evaluation (99213) if performed by a physical or occupational therapist. These ROM measurements were performed by a doctor of chiropractic. Reimbursement recommended of $36.00.

HCPCS code E0745 for dates of service 5-24-02 was denied by the carrier as "T – Not according to Treatment Guidelines." Article 6 of House Bill 2600, adopted during the 77th Texas Legislative Session, 2001, states that treatment guidelines adopted under Chapter 413 of the Texas Labor Code are abolished on January 1, 2002. The resubmission EOB's also showed an "additional denial code - U-Unnecessary medical treatment." The review will be per the 96 MFG. Texas Labor Code 413.011 (d) and Rule 133.304 (i) (1-4) place certain requirements on the Requestor when billing for services for which the Division has not established a maximum allowable reimbursement. Per Rule 133.307(g)(3)(D), the Requestor is required to discuss, demonstrate and justify that the payment being sought is a fair and reasonable rate of reimbursement. The Requestor has not provided sample EOBs or other evidence that the fees billed are for similar treatment of injured individuals and that reflect the fee charged to and paid by other carriers. Recommend no reimbursement.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.305, House Bill 2600, 1996 Medical Fee Guideline

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 additional reimbursement in the amount of $36.00**.**

Findings and Decision and Order by:

	Donna Auby	4-17-06
Authorized Signature	Typed Name	Date of Findings and Decision

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.