



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 Issues

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address:	MDR Tracking No.: M5-06-1383-01
John A. Felker III, D. C. 2434 South Main Stafford, Texas 77477	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
Liberty Insurance Corp., Box 28	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 that they followed the recommendations of the doctor and documented this in their clinic notes.

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)
4-2-05 – 7-6-05	CPT code 99214	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$97.40
4-2-05 – 7-6-05	CPT code 97140-59 (\$31.79 X 30 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$953.70
4-2-05 – 7-6-05	CPT code 95833-59 (See note below)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	0
4-2-05 – 7-6-05	CPT code 98940 (\$31.37 X 31 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$972.47
4-2-05 – 7-6-05	CPT code 97110 (\$33.56 X 24 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$805.44
4-2-05 – 7-6-05	CPT code 97530 (\$35.16 X 22 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$773.52
4-2-05 – 7-6-05	CPT codes G0283, 97012, 97035	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
	Total		\$3,602.53

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.

Note: CPT code 95833 is considered by Medicare to be a component procedure of CPT code 98940 and 97530. There are no circumstances in which a modifier would be appropriate. The services represented by the code combination will not be paid separately.

Date of service 3–28-05 was withdrawn by the requestor in a letter dated 4-27-06 and will not be a part of this review.

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 \$3,602.53.

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 4-20-06 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 97140-59GP on 4-20-05 was denied by the carrier as "N – not appropriately documented." The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Reimbursement of \$31.79 is recommended.

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 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 additional reimbursement in the amount of \$3,634.32. 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:

Authorized Signature

Donna Auby, Medical Dispute Officer

Typed Name

5-30-05

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.

May 18, 2006

TDI, Division of Workers' Compensation
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-06-1383-01
DWC#:
Injured Employee:
DOI:
IRO Certificate No.: IRO 5055

Dear Ms. ____:

IRI has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc. and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him 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 Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is licensed in chiropractic, and is currently on the DWC Approved Doctor List.

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,

:dd

REVIEWER'S REPORT M5-06-1383-01

Information Provided for Review:

DWC-60, Table of Disputed Services, EOB's

Information provided by Requestor:

Correspondence

MRI report, Functional Capacity Eval, initial ortho consult report & notes from other
Treating MD

Physical Therapy Notes 03/25/05 – 07/06/05

Information provided by Respondent:

Designated Reviews

Treating MD:

Office Visits 03/16/05 – 06/29/05

Radiology Report 03/09/05

Clinical History:

The records indicate that the patient was injured on the job on ___ in an industrial-related lifting incident. The patient could not straighten up, and when he finished completing the required paperwork, they took him to the hospital emergency room for an examination. He was evaluated and given an injection. Afterwards he saw the company doctor who took him off work a week and returned him to light duty working in the warehouse. Over the next few weeks he received minimal treatment. On 02/04/05 he was placed at maximum medical improvement by his treating doctor and given a 0% impairment rating. He continued to experience pain and was assessed by another doctor on 02/18/05.

Disputed Services:

Office visit 99214, manual therapy technique 97140-59, electric stimulation GO283, muscle testing whole body 95833-59, chiropractic manipulative treatment 98940, mechanical traction 97012, therapeutic exercise 97110, ultrasound 99735, and therapeutic activities 97530 through dates of service 04/02/05 through 07/06/05.

Decision:

The review partially agrees with the determination of the insurance company in this case.

Rationale:

As mentioned above, the patient was initially injured and received limited care. On 02/18/05 he was seen by another doctor who did an evaluation and began an aggressive treatment program. Over the course of treatment, MRI scan was done on 03/09/05, which revealed disc involvement. The patient was referred to an orthopedic specialist for determination if he was a candidate for injection therapy. Appropriate medication was prescribed. The doctor recommended continuation of therapy and treatment in an attempt to avoid epidural steroid injections. In addition, functional capacity evaluation on 04/07/05 indicated that the patient was not in a position to return to his regular duty occupation. Given the subjective symptoms and objective findings and functional capacity evaluation, an aggressive treatment program was needed in this case. National treatment guidelines allow for this type of treatment for this type of injury. However, there are no national treatment guidelines that allow for continuation of ongoing passive therapy some 3 months post injury. There is sufficient documentation on each day that serves to clinically justify the treatment codes of office visit 99214, manual therapy technique 97140-59, muscle testing of whole body 95833-59, chiropractic manipulative treatment 98940, therapeutic exercises 97110, therapeutic activities 97530 for dates of service 04/02/05 through 07/06/05. There is no documentation or clinical justification for the use of continued passive therapy in the form of electrical stimulation 30283, mechanical traction 97012, or ultrasound 97035 during that same period.

SCREENING CRITERIA/TREATMENT GUIDELINES/ PUBLICATIONS UTILIZED:

In addition to my 20 years of active practice in chiropractic in the State of Texas, I also used ACOEM Guidelines, Official Disability Guidelines, and the Guidelines for Chiropractic Quality Assurance and Practice Parameters in arriving at my determination.