



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	
Requestors Name and Address: Clinica Santa Ana/Basu Law Firm P O BOX 550496 Houston, Texas 77255	MDR Tracking No.: M5-06-1554-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: American Casualty Company Rep Box # 47	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

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

Requestor's Position Summary: "...the treatment provided for the claimant was medically reasonable and necessary. We are requesting reimbursement for all disputed dates of services".

Principle Documentation:

1. DWC-60/Table of Disputed Services
2. CMS 1500's
3. Explanation of Benefits

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

Respondent's Position Summary: No position summary submitted

Principle Documentation: Response to DWC-60

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
07-05-05 to 11-21-05	99213 (\$67.20 X 2 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$134.40
	97032 (1 unit @ \$20.34 X 18 DOS)		\$366.12
	97035 (1 unit @ \$15.53 X 2 DOS)		\$31.06
	97124 (1 unit @ \$28.51 X 1 DOS)		\$28.51
	97110 (4 units @ \$143.44 X 17 DOS)		\$2,438.48
	99212 (\$48.03 X 15 DOS)		\$720.45
<b>TOTAL</b>			<b>\$3,719.02</b>

#### 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 **prevailed** on the disputed medical necessity issues.

Based on review of the disputed issues within the request, the Medical Review 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 05-10-2006, 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 99212 billed on date of service 08-15-05 was denied by the carrier with denial codes 38/880-149 (services not provided or authorized by designated (network/primary care) providers/denied per insurance: treatment not approved by treating physician 100%). The provider of services, Dr. Fernando Franco, is the treating doctor of record. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$48.03**.

CPT code 97032 (1 unit) billed on date of service 08-25-05 was denied by the carrier with denial codes 38/880-149 (services not provided or authorized by designated (network/primary care) providers/denied per insurance: treatment not approved by treating physician 100%). The provider of services, Dr. Fernando Franco, is the treating doctor of record. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$20.34**.

CPT code 97150 (4 units) billed on date of service 08-25-05 was denied by the carrier with denial codes 38/880-149 (services not provided or authorized by designated (network/primary care) providers/denied per insurance: treatment not approved by treating physician 100%). The provider of services, Dr. Fernando Franco, is the treating doctor of record. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$89.00 (\$22.25 X 4 units)**.

CPT code 97032 billed on dates of service 08-30-05 (1 unit), 09-01-05 (1 unit), 09-13-05 (1 unit), 09-20-05 (1 unit) and 09-30-05 (1 unit) was denied by the carrier with denial codes 16/880-134 (claim/service lacks information which is needed for adjudication/charge denied due to lack of sufficient documentation of services rendered 100%). Per Rule 133.307(g)(3)(A-F) the Requestor submitted documentation that supports the services billed. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$101.70 (\$20.34 X 5 units)**.

CPT code 97110 billed on dates of service 08-30-05 (3 units), 09-01-05 (4 units), 09-13-05 (4 units), 09-20-05 (4 units) and 09-30-05 (4 units) were denied by the carrier with denial codes 16/880-134 (claim/service lacks information which is needed for adjudication/charge denied due to lack of sufficient documentation of services rendered 100%). Per Rule 133.307(g)(3)(A-F) the Requestor submitted documentation for review, however, 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, Medical Dispute

Resolution has reviewed the matters in light all of the Commission requirements for proper documentation. Medical Dispute Resolution 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, therefore, reimbursement is not recommended.

CPT code 99212 billed on dates of service 09-20-05 and 09-30-05 were denied by the carrier with denial codes 16/880-134 (claim/service lacks information which is needed for adjudication/charge denied due to lack of sufficient documentation of services rendered 100%). Per Rule 133.307(g)(3)(A-F) the Requestor submitted documentation that supports the services billed. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$96.06 (\$48.03 X 2 DOS)**.

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

28 Texas Administrative Code Sec. 133.308, 133.307(g)(3)(A-F) and 134.202(c)(1)  
Texas Labor Code 413.031 and 413.016

**PART VII: DIVISION DECISION AND ORDER**

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 reimbursement in the amount of \$4,074.15. In addition, the Division finds that the Requestor was the prevailing party and is entitled to a refund of the IRO fee \$460.00. The Division hereby **ORDERS** the Respondent 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.

Ordered by:

07-24-06

\_\_\_\_\_  
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.**

**Envoy Medical Systems, LP**  
**1726 Cricket Hollow**  
**Austin, Texas 78758**

Phone 512/248-9020

Fax 512/491-5145

IRO Certificate #4599

**NOTICE OF INDEPENDENT REVIEW DECISION**

June 26, 2006

**Re: IRO Case # M5-06-1554 –01** \_\_\_\_\_

Texas Department of Insurance, Division of Workers' Compensation:

Envoy Medical Systems, LP (Envoy) has been certified as an Independent Review Organization (IRO) by the Texas Department of Insurance and has been authorized to perform independent reviews of medical necessity for Division of Workers' Compensation cases. Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that cases be assigned to certified IROs, this case was assigned to Envoy for an independent review. Envoy has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, Envoy received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic, who is licensed in Texas, and who has met the requirements for the Division of Workers' Compensation Approved Doctor List or who has been granted an exception from the ADL. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and the injured employee, the injured employee's employer, the insurance carrier, the utilization review agent, any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to Envoy for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the Envoy reviewer who reviewed this case, based on the medical records provided, is as follows:

Medical Information Reviewed

1. Table of disputed services
2. Explanation of benefits
3. Response to IRO request for records 5/15/6
4. Initial report Dr. Basu
5. TWCC work status reports
6. Daily notes and progress reports, Dr. Basu
7. Reports, Dr. Aggawal
8. MRI report lumbar spine 6/6/05
9. Rebuttal to DD report 6/30/05, Dr. Basu
10. Electrodiagnostic report 7/18/05
11. FCE reports 7/19/05, 12/13/05, 9/28/05
12. Review 8/17/05, Dr. van Hal
13. Letter of medical necessity 8/9/05
14. Report 10/4/05, Dr. Tomazik
15. RME report 11/3/05
16. RME 12/2/05
17. DD reports 11/9/05, 2/22/06
18. Preauthorization request 12/1/05
19. Surgical reports for ESI
20. Position statement, Dr. Basu
21. Reports 1/9/06, 3/13/06, Dr. Ruben

### History

The patient injured his lower back in \_\_\_\_, and initiated treatment with his treating D.C. immediately. He has been treated with physical therapy, medication, lumbar ESIs and chiropractic care.

### Requested Service(s)

Office visits, electrical stimulation, ultrasound, massage therapy, therapeutic exercises 7/5/05 – 11/21/05.

### Decision

I disagree with the carrier's decision to deny the requested services.

### Rationale

The patient has an L4-L5 disk protrusion and a right lumbar radiculopathy. He has undergone an extensive course of both active and passive therapy with beneficial results. The documentation from the treating D.C. supports the treatment prior to the start of a series of three lumbar ESIs on 7/15/05, 8/19/05, and 9/19/05. Initially the patient's VAS was 10/10, and under the D.C.'s care it was reduced to 6/10 prior to the first ESI on 7/15/05. Treatment to that point was reasonable and necessary.

On 7/15/05, the patient had his first injection. He underwent active rehabilitation following each injection. The medical rationale for active and passive therapy post-injection is that spinal injections have a longer effect when combined with structural rehabilitation, therapy reduces the time to reach MMI, therapy reduces the need for a series of injection by protocol, reduces morbidity, may reduce return-to-work time, and may reduce the necessity for surgical intervention. The records from the treating D.C. show that the patient was responding to treatment. The patient reached light duty status, and surgery was not needed. The treatment provided resulted in the relief of pain and improved function during the time period covered in this dispute.

The D.C.'s records show objective, quantifiable findings to support treatment. The services in dispute were reasonable and necessary based on the severity of injury, intensity of services and appropriateness of care.

This medical necessity decision by an Independent Review Organization is deemed to be a Workers' Compensation Division decision and order.

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 a 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 the 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 must be received by the Division of Workers' Compensation, chief Clerk of Proceedings, within then (10) days of your receipt of this decision.

Sincerely,

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Daniel Y. Chin, for GP