



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

| | |
|---|---------------------------------|
| Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier | |
| Requestor's Name and Address: Summit Rehabilitation Centers 2420 Randol Mill Road Arlington, Texas 76011 | MDR Tracking No.: M5-06-1682-01 |
| | Claim No.: |
| | Injured Employee's Name: |
| Respondent's Name and Address: Texas Mutual Insurance Company Rep Box # 54 | Date of Injury: |
| | Employer's Name: |
| | Insurance Carrier's No.: |

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: The Requestor did not submit a Position Summary to MDR.

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: The position statement submitted by Texas Mutual does not address the disputed issues.

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) |
|---|--|---|--------------------------------|
| 06-28-05 to 12-30-05 | 99213 (\$68.31 X 14 DOS)(*excluding DOS below) | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$956.34 |
| 7-12-05, 08-01-05, 10-13-05 & 12-06-05 | 96004 (\$155.25 X 4 DOS) | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$621.00 |
| 07-12-05 to 07-21-05 | 97110 (3 units @ \$108.42 X 5 DOS) | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$542.10 |
| 07-12-05 to 07-21-05 | 97140-59 (1 unit @ \$34.16 X 5 DOS) | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$170.80 |
| 08-01-05 | 97140 (1 unit @ \$34.16 X 1 DOS) | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$34.16 |
| 11-09-05 | 99070 | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$10.00 |
| 06-29-05 to 08-01-05 | 97012, 98940 and G0283 | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | \$0.00 |
| 06-29-05, 07-12-05, 07-13-05 and 07-21-05 | * 99213 | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | \$0.00 |
| TOTAL | | | \$2,334.40 |

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 **majority** of the disputed medical necessity issues.

Based on review of the disputed issues within the request, Medical Dispute Resolution has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained fee issues that were not addressed by the IRO and will be reviewed by Medical Dispute Resolution.

On 06-20-06, Medical Dispute Resolution submitted a Notice to the 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.

An updated Table of Disputed Services received from the Requestor on 06-13-06 is used for this review.

CPT code 99080-73 billed on dates of service 07-25-05 and 12-27-05 was denied by the Respondent with denial codes "W1/248" (Workers Compensation State Fee Schedule Adjustment/DWC-73 not properly completed or submitted in excess of the filing requirements; reimbursement denied per Rule 129.5). Per Rule 133.307(g)(3)(A-F) the Requestor did not submit documentation for review. No reimbursement recommended.

CPT code 99213 billed on date of service 08-23-05 was denied by the Respondent with denial code "97" (payment is included in the allowance for another service/procedure). Per the 2002 Medical Fee Guideline, CPT code 99213 is a component procedure of code 99455 billed on date of service 08-23-05. In addition "there are no circumstances in which a modifier would be appropriate. The services represented by the code combination will not be paid separately." No reimbursement recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.202(c)(1), 129.5 and 133.307(g)(3)(A-F)
Texas Labor Code, Sec. 413.031 and 413.011 (a-d)

PART VII: DIVISION FINDINGS 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 \$2,334.40. In addition, the Division finds that the Requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of \$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.

Order by:

08-11-06

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.

NOTICE OF INDEPENDENT REVIEW DECISION

July 10, 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 #: M5-06-1682-01
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 picking up 50 pound boxes and felt an immediate onset of pain. He was seen by the company doctor. He continued to have problems and was seen by a new treating doctor. He was evaluated and an aggressive passive therapy program was begun with progression to active physical rehabilitation. An MRI dated 12/15/04 revealed significant positive findings that led his doctor to begin an appropriate treatment program. He had several DDE appointments and was found not to be at MMI until 12/09/05. Since he continued to experience problems, he was referred for injection therapy and he received additional therapy in conjunction with his lumbar epidural steroid injections (LESI).

Requested Service(s)

99213-Office visit, 97140-59-Manual therapy technique, 98940-Chiropractic manipulation, 96004-Physician review of motion

tests, 97110-Therapeutic exercises, 97012-Mechanical traction, G0283-Electrical stimulation, and 99070-Supplies provided from 06/28/05 through 12/30/05.

Decision

It is determined that the 99213-Office visit at once per week, 97140-59-Manual therapy technique, 96004-Physician review of motion tests, 97110-Therapeutic exercises, and 99070-Supplies provided from 06/28/05 through 12/30/05 were medically necessary to treat this patient's condition.

It is determined that the 99213-Office visit more than one per week, 98940-Chiropractic manipulation, 97012-Mechanical traction, and G0283-Electrical stimulation provided from 06/28/05 through 12/30/05 were not medically necessary.

Rationale/Basis for Decision

The medical record documentation substantiates the medical necessity for this patient to receive one office visit (99213) on a weekly basis, physician review of motion tests (96004), supplies (biofreeze analgesic ointment) (99070), manual therapy technique (97140-59), as well as all units of therapeutic exercises (97110) from 06/28/05 through 12/30/05. It was not medically necessary for him to receive chiropractic manipulation (98940), mechanical traction (97012) or electrical stimulation (G0283) during this same time frame as it had been over eight months since his injury. The patient had already received several months of chiropractic manipulation and passive therapy prior to the injections. Therefore there is no clinical justification for chiropractic manipulation and/or passive therapy in conjunction with injection therapy this many months after an injury.

National treatment guidelines allow for active therapy (exercises) post ESI's. Up to 6 sessions would be considered reasonable after each injection. There is sufficient documentation to clinically justify the active exercises rendered during the above period of time as well as a weekly office visits to properly manage his treatment. In addition, supplies (biofreeze analgesic ointment) (99070), and manual therapy technique (97140-59) were also medically necessary. However, there are no supportive documentation or treatment guidelines that warrant the use of chiropractic manipulation (98940), mechanical traction (97012) or electrical stimulation (G0283) during the time frame listed above.

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