



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 Dispute

PART I: GENERAL INFORMATION

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

Requestor's Name and Address:

Carl M. Naehritz III, D. C.
2900 Hwy 121, Suite 120
Bedford, TX 76021

MDR Tracking No.:

M5-06-1706-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:

Box 17

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary states, "After many unsuccessful attempts to resolve the issue of medial necessity and medical payments with Bunch and Associate Insurance Company, I am submitting the enclosed file along with all the original HCFA's and Resubmitted HCFA's with EOB's attached...I respectfully request the Board to find that care was medically necessary and all bills should be paid immediately with penalty and interest due at 50% as set up in the TDI rule and regulations 133.304(D)."

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. CMS-1500's
3. EOB's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary states, "...medical treatment must be documented to show how the treatment cures or relieves the injury and helps facilitate the Claimant's return to work. Requestor has not done this. His excessive chiropractic treatments are not medically necessary, and reimbursement should be denied."

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. EOB's

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)
12-07-05 – 1-30-06	99212 (\$48.03 x 4 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$192.12
9-21-05 – 1-06-06	99213 (\$65.44 x 6 DOS '1 <MAR') (\$65.58 x 1 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$458.22
9-21-05 – 11-23-05	97140 (\$33.04 x 16 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$528.64
9-21-05 – 11-23-05	97035 (\$15.11 x 13 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$196.43
9-21-05 – 12-13-05	E1399 (\$15.00 x 3 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$45.00
10-24-05	99080 (special report)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$50.00
1-10-06	A4595	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$36.01
2-15-06	99372	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	0
9-21-05 – 4-12-06	97112, 97530, 97110, 98940, 98941, 72020	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
	Grand Total		\$1,506.42

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 Requestor billed \$36.01 for HCPC code A4595 on 1-10-06. The insurance carrier denied payment based upon medical necessity. The IRO determined that this item was medically necessary. Recommend reimbursement per the DMEPOS Fee Schedule of \$36.01.

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 \$1,506.42.

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 6-15-06 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 99213-59 on 4-12-06 was denied by the Respondent as "F-Fee Guideline MAR Reduction." The Respondent made no payment. Recommend reimbursement per Rule 134.202(c)(1) of \$65.58.

CPT code 99080-73 on 4-12-06 was denied by the Respondent as "F-Fee Guideline MAR Reduction." The Respondent made no payment. Recommend reimbursement per Rule 129.5(i) of \$12.00(<MAR).

Regarding CPT code 99455-RP on 3-6-06: Per the Requestor's medical notes this service was a review of the Disability Exam report. The Requestor did not submit this service to the Respondent appropriately per Rule 134.202(b). Recommend no reimbursement.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d) and 413.031
28 Texas Administrative Code Sec. 129.5, 134.1, 134.202, 133.308

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 Respondent 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 \$1,584.00. 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.

Findings and Decision and Order by:

10-06-06

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 12, 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 #: M5-06-1706-01
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 moving a pallet of freight that weighed 500 pounds. While stopping the pallet, it rolled over onto his foot. A CT scan of the left foot confirmed a non-displaced fracture of the base of the fifth metatarsal. The patient underwent chiropractic treatments and the fracture healed without surgical intervention.

Requested Service(s)

(99212/99213) Office visits, (97140) manual therapy technique, (97112) neuromuscular re-education, (97035) ultrasound, (E1399) DME, (99080) special report, (97530) therapeutic activities, (97110) therapeutic exercises, (98940/98941) chiropractic manipulative treatment, (72020) radiological exam single view, (A4595) electrical stimulator supplies, and (99372) phone call provided from 09/21/05 through 04/12/06.

Decision

It is determined that the (99212/99213) office visits, (97140) manual therapy technique, (97035) ultrasound, (E1399) DME, (99080) special report, (A4595) electrical stimulator supplies, and (99372) phone call provided from 09/21/05 through 04/12/06 were medically necessary to treat this patient's condition.

It is determined that the (97112) neuromuscular re-education, (97530) therapeutic activities, (97110) therapeutic exercises, (98940/98941) chiropractic manipulative treatment, (72020) radiological exam single view, provided from 09/21/05 through 04/12/06 were not medically necessary.

Rationale/Basis for Decision

The treating doctor recommended a treatment program and it was begun. Therapy was performed from 08/24/05 through 09/21/05. The patient was not responding satisfactorily and even after it was determined that the patient was healing slowly, the same therapy was continued. Once the patient saw the orthopedic specialist on 09/26/05 and it was confirmed that the fracture was slow to heal and the patient was placed in a boot. Active therapy should have stopped until the fracture healed sufficiently to begin a rehabilitation program. Therefore, during the dates of services from 09/21/05 through 04/12/06, (99212/99213) office visits, (97140) manual therapy technique, (97035) ultrasound, (E1399) DME, (99080) special report, (A4595) electrical stimulator supplies, and (99372) phone call were medically necessary to treat this patient's on the job injury.

During the dates of service listed above, there is no justification for (98940 and 98941) chiropractic manipulative treatment for treatment of the fracture. In addition, there was no justification for (97112) neuromuscular re-education, (97530) therapeutic activities, or (97110) therapeutic exercises until the fracture had healed. (72020) radiological examination spine single view was not medically necessary for treatment of this injury.

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

Information Submitted to TMF for Review

Patient Name: ____ Tracking #: M5-06-1706-01

Information Submitted by Requestor:

- Letters from Texas Back Care/Accident & Injury Center
- Progress Notes
- Comprehensive Examinations
- Disability Certificates
- Prescriptions from Dr. Naehritz
- Office notes from Dr. Naehritz
- Prescription for Course of Treatment Authorization
- Letter of Medical Necessity and Pertinent Doctor Notes
- Report of CT scan of left foot
- Return to Work Certificates
- New Patient Evaluation from Dr. Banta
- Pre-authorization requests
- Decision letter
- Initial Evaluation for Maximum Medical Improvement
- History and Physical Examination from Dr. Cotton
- Examination by Dr. Parkhill
- Rebuttal on Review
- Review by Dr Klemis
- Office notes from Dr. Van Hal
- Imaging results of bone scan
- X-ray reports of left foot

Information Submitted by Respondent:

- Letter from Attorneys
- Injured Employee Treatment Plan
- Worker's Compensation Status Reports
- Disability Certificates
- Progress Notes
- Prescriptions
- Report of CT scan of left foot
- Office notes from Dr. Van Hal
- Report of Maximum Medical Improvement
- Return to Work Certificate
- Report of x-rays of left foot
- Examination by Dr. Parkhill