



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	
Requestor's Name and Address: Summit Rehabilitation Centers 2420 E Randol Mill Road Arlington, Texas 76011	MDR Tracking No.: M5-06-1708-01
	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: "Provider sent a request for reconsideration on February 18, 2005. Proof that carrier received request is also included. Carrier chose not to respond within 28 day time frame rule. TWCC Rule 133.307(j)(2) says only the reason brought up by the carrier can be heard at MDR. SOAH decisions say if the carrier doesn't care to respond then they lose their opportunity to put in a reason. If no reason is put in by carrier as to the denial the commission puts it as an "F". All Fee guidelines have been followed."

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: None submitted by Respondent to MDR.

Principle Documentation: No response submitted by Respondent to MDR.

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS (Medical Necessity)

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
05-26-04 to 10-29-04	97022 (1 unit @ \$18.48 X 8 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$147.84
	97110 (1 unit @ \$35.69 X 8 DOS)		\$285.52
	97110 (1 unit @ \$31.79 X 1 DOS)		\$31.79
	97140 (1 unit @ \$32.90 X 10 DOS)		\$329.00
	G0283 (1 unit @ \$13.90 X 2 DOS)		\$27.80
05-26-05 to 10-29-04	97116, 97113, 98940, 99354 and 99213	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
<b>TOTAL</b>			<b>\$821.95</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 **did not prevail** on the **majority** of 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 06-02-06, the Medical Review Division 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.

CPT code 97110 billed on date of service 05-28-04 was denied by the Respondent with denial code G (unbundling). Per the 2002 Medical Fee Guideline CPT code 97110 is considered to be a component procedure of CPT code 97113 billed on the date of service in dispute. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be considered justifiable if a modifier is used appropriately. The Requestor did not bill with a modifier, therefore, no reimbursement is recommended.

CPT code 99213 billed on dates of service 06-30-04, 07-19-04, 07-22-04, 07-26-04, 07-28-04, 08-02-04 and 08-10-04 were denied by the Respondent with denial codes MU/N/F (physical medicine and rehabilitation services may not be reported in conjunction with an evaluation and management code performed on the same day/not appropriately documented/Fee guideline MAR reduction). The Respondent has made no payment. Per the 2002 Medical Fee Guideline physical medicine and rehabilitation services can be reported in conjunction with an evaluation and management code performed on the same day. Per Rule 133.307(g)(3)(A-F) the Requestor submitted documentation for review which supported the services provided. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$456.26 (\$65.18 X 7 DOS)**.

CPT code 99080-73 billed on date of service 07-16-04 was denied by the Respondent with denial code F/TD (Fee guideline MAR reduction/the work status report was not properly completed or was submitted in excess of the filing requirements, therefore, reimbursement is denied per Rule 129.5). Review of the DWC-73 submitted by the Requestor revealed that the Requestor had not filed a complete report per Rule 129.5(c)(1-5). No reimbursement is recommended.

CPT code 95851 billed on date of service 08-10-04 was denied by the Respondent with denial code G (unbundling). Per the 2002 Medical Fee Guideline CPT code 95851 is considered to be a component procedure of CPT code 99213 billed on the date of service in dispute. There are no circumstances in which a modifier would be appropriate. The services represented by the code combination will not be paid separately, therefore, no reimbursement is recommended.

CPT code 96004 billed on date of service 08-10-04 was denied by the Respondent with denial codes G and F (unbundling and Fee guideline MAR reduction). Per the 2002 Medical Fee Guideline CPT code 96004 is not global to other services billed on date of service 08-10-04. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$148.03**.

Review of CPT code 97750-FC billed on date of service 09-22-04 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the Requestor submitted convincing evidence that the Respondent was in receipt of the Requestor's request for an EOB. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$249.62**.

Review of CPT code 99080-73 billed on date of service 10-08-04 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the Requestor submitted convincing evidence that the Respondent was in receipt of the Requestor's request for an EOB. Reimbursement is recommended per Rule 129.5(i) in the amount of **\$15.00**.

Review of CPT code 99213 billed on date of service 10-18-04 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the Requestor submitted convincing evidence that the Respondent was in receipt of the Requestor's request for an EOB. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$65.18**.

Review of CPT code 97545-WC billed on dates of service 10-25-04 (1 unit) and 10-27-04 (1 unit) revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(A) the Requestor did not submit copies of CMS 1500s for review, therefore, it cannot be determined if the services were provided. In addition per Rule 133.307(g)(3)(A-F) the Requestor did not submit documentation for review. No reimbursement is recommended.

Review of CPT code 97546-WC billed on dates of service 10-25-04 and 10-27-04 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(A) the Requestor did not submit copies of CMS 1500s for review, therefore, it cannot be determined if the services were provided. In addition per Rule 133.307(g)(3)(A-F) the Requestor did not submit documentation for review. No reimbursement is recommended.

CPT code 97546-WC billed on dates of service 10-26-04 (5 units), 10-28-04 (5 units) and 10-29-04 (5 units) was denied by the Respondent with denial codes N/207 (not appropriately documented/need valid Texas Fee Guideline code). Per Rule 133.307(g)(3)(A-F) the Requestor submitted documentation that supported the services billed. Code 97546-WC is a valid Texas Fee Guideline code. Reimbursement per Rule 134.202-(e)(5)(b) is recommended in the amount of **\$432.00 (\$144.00 X 3 DOS)**.

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

28 Texas Administrative Code Sec. 133.308, 133.307(e)(2)(A), 133.307(e)(2)(B), 133.307(g)(3)(A-F), 134.202, 134.202(c)(1), 134.202(e)(5)(b), 129.5(c)(1-5) and 129.5(i)  
Texas Labor Code, Sec. 413.031

#### **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 \$2,188.04. In addition, the Division finds that the Requestor was not the prevailing party and is not entitled to a refund of the IRO fee. 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:

08-01-06

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

# MEDICAL REVIEW OF TEXAS

[IRO #5259]

10817 W. Hwy. 71  
Phone: 512-288-3300

Austin, Texas 78735  
FAX: 512-288-3356

## NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	
MDR Tracking Number:	M5-06-1708-01
Name of Patient:	
Name of URA/Payer:	Summit Rehab Centers
Name of Provider: (ER, Hospital, or Other Facility)	Summit Rehab Centers
Name of Physician: (Treating or Requesting)	Luz D. Gonzalez, DC

June 30, 2006

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on the Division of Workers' Compensation Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD  
Medical Director

cc: Division of Workers' Compensation

### DOCUMENTS REVIEWED

1. Notification of IRO Assignment, Table of Disputed Services, Carrier EOBs
2. Treating doctor's position statement regarding dispute, dated 6/16/06
3. MRI report of right knee, 3/29/04
4. Reports and records from the referral orthopedist, multiple dates
5. Notes from surgeon, dated 5/19/04, 8/18/04
6. Operative report, dated 7/15/04
7. Prescriptions for therapy from the surgeon, dated 7/16/04
8. Examination and report from referral medical doctor, dated 8/12/04, 8/19/04, 9/2/04
9. Treating doctor's daily "clinical notes," multiple dates

### CLINICAL HISTORY

Patient is a 70-year-old male cement worker who was leveling a surface when he tried to step over some metal rods and his right knee was forced into an awkward position, and it twisted. He had immediate onset of right

knee pain and swelling. He was seen initially by the company doctor and returned to work with some limitations. He continued to experience significant pain and swelling, so in March of 2004, he changed treating doctors to a doctor of chiropractic who immediately ordered an MRI that revealed a "severe tear" of the posterior horn of the medial meniscus, AVN on the medial femoral condyle, and "significant sprain and disruption" of the ACL, sprain of the PCL, and probably subtle tear of the posterior horn of the lateral meniscus.

When initial conservative therapy and rehabilitation attempts failed, he underwent an injection protocol, followed by additional post-injection physical therapy and rehabilitation. When that also failed, on 7/15/04 he underwent arthroscopy with excision of the lateral and medial menisci, debridement of a partial tear of the ACL, synovial resection, and chondral shaving of the medial joint compartment and patella, followed by post-operative physical therapy and rehabilitation.

In August and September 2004, he received continued to receive medications for pain, and even underwent another series of injections, followed by a work conditioning and a work hardening program.

#### REQUESTED SERVICE(S)

Whirlpool therapy (97022), therapeutic exercises (97110), aquatic therapy (97113), gait training (97116), unattended electrical stimulation (G0283), established patient office visit, level III (99213), manual therapy techniques (97140), chiropractic manipulative treatment, spinal 1-2 areas (98940), and prolonged physician services (99354) for dates of service 5/26/04 through 10/29/04.

#### DECISION

The therapeutic exercises (97110), the manual therapy techniques (97140), the unattended electrical stimulation treatments (G0283), and the whirlpool treatments (97022) are all approved throughout the date range in dispute.

The gait training (97116), the aquatic exercises (97113), the chiropractic manipulative therapies, spinal 1-2 areas (98940), the prolonged physician service (99354), and the level III established patient office visits (99213) are all denied for the dates of service in dispute.

#### RATIONALE/BASIS FOR DECISION

The medical records submitted adequately document that a compensable injury occurred for which the claimant needed treatment. The records further demonstrated that the patient underwent a trial of injections, and when these injections failed to produce the desired result, the patient underwent a significant surgical procedure, both of which required follow-up physical therapy and rehabilitation. Therefore, the therapeutic exercises, manual therapy techniques, unattended electrical stimulation and the whirlpool treatments were all supported as medically necessary.

However, in terms of the aquatic exercises (97113), the medical records failed to document and support the medical necessity of this service as opposed to utilization of a straight "land based" protocol. According to a Medicare Medical Policy Bulletin<sup>1</sup>, documentation for this service must show objective loss of joint motion, strength, or mobility (e.g., degrees or motion, strength grades, levels of assistance) and reflect the medical necessity of the treatment. Other forms of exercise therapy may be medically necessary in addition to aquatic therapy **when the patient cannot perform land based exercises effectively to treat his/her condition without first undergoing the aquatic therapy, or when aquatic therapy facilitates progress to land based exercise or increased function.** [emphasis added] But in this case, the patient was already safely receiving land-based services at the time these aquatic procedures were initiated. Therefore, since the records failed to document the rationale for the necessity of these procedures, they were unsupported as medically necessary.

In terms of the gait training services (97116), nothing in the records from either the treating doctor of chiropractic or the referral medical doctors (surgeons, orthopedists, or general practice MDs) had in their findings any references to a gait disturbance or abnormality that would otherwise necessitate the performance of this procedure. In fact, the office note from the referring orthopedist, dated 5/24/04 – right before the dates of service in dispute commenced – indicated only "medial knee pain with crepitation symptoms" and "range of motion 0-120 [degrees] with pain on extremes." No mention of any gait abnormality was in the record. According to the aforementioned Medicare Medical Policy Bulletin<sup>1</sup>:

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<sup>1</sup> HGSA Medicare Medical Policy Bulletin, Physical Therapy Rehabilitation Services, original policy effective date 04/01/1993 (Y-1B)

“Specific indications for gait training include but are not limited to:

- the patient having suffered a cerebral vascular accident resulting in impairment in the ability to ambulate, now stabilized and ready to begin rehabilitation.
- the patient having recently suffered a musculoskeletal trauma, requiring ambulating reeducation
- the patient having a chronic, progressively debilitating condition for which safe ambulation has recently become a concern
- the patient having had an injury or condition that requires instruction in the use of an assistive device, e.g., walker, crutches, or cane
- the patient having been fitted with a brace/lower limb prosthesis and requires instruction in ambulation
- the patient having a condition that requires training in stairs/steps or chair transfer in addition to general ambulation”

The records failed to objectively support any of these criteria. Therefore, this service was unsupported as medically necessary.

Insofar as the chiropractic manipulative therapy, spinal 1-2 areas procedure (98940) that was performed on date of service 7/2/04, nothing in either the diagnosis or the medical records provided any rationale for why a manipulation *to the patient's spine* was necessary to perform. Therefore, this service was also unsupported as medically necessary.

With regard to the prolonged physician service (99354) that was performed on 8/17/04, the record that referenced this service on that date was an entry entitled “Case Management,” and it stated: “Issued ice machine and instructed him on use. He is also to follow-up with surgeon tomorrow.” However, according to CPT 2, “Codes 99354-99357 are used when a physician provides prolonged service involving direct (face-to-face) patient contact that is beyond the usual service in either the inpatient or outpatient setting. This service is reported in addition to other physician service, including evaluation and management services at any level. Appropriate codes should be selected for supplies provided or procedures performed in the care of the patient during this period.” CPT goes on to state that “Either code also may be used to report a total duration of prolonged service of 30-60 minutes on a given date,” and that “Prolonged service of less than 30 minutes total duration on a given date is not separately reported because the work involved is included in the total work of the evaluation and management codes.” Based on this description from CPT, the documentation submitted for date of service 8/17/04 failed to support the medical necessity of this service.

And finally, in terms of the level III established patient office visits (99213), nothing in either the diagnosis or the medical records in this case supported the medical necessity for performing this high a level of Evaluation and Management (E/M) service on each and every visit, *particularly* not during an already-established treatment plan and while under the concurrent care of so many other physician-level providers.

#### Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that I have no known conflicts of interest between the provider 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 IRO.

# 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.

Chief Clerk of Proceedings  
Division of Workers' Compensation  
P.O. Box 17787  
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

Signature of IRO Employee: \_\_\_\_\_

Printed Name of IRO Employee: Cindy Mitchell