



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

Requestors Name and Address: Valley Spine Medical Center 5327 S. McColl Road Edinburg, Texas 78539	MDR Tracking No.: M5-06-1743-01
	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: Per the Table of Disputed Services "The care rendered to the patient has met criteria set by Texas Labor code section 408.21 complete rationale for increase reimbursement can be found in the medical records of the complete Medical Dispute."

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 services.

Principle Documentation:

1. 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)
06-16-05	97535	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
06-16-05	E1399	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
06-22-05 to 08-31-05	97035 (1 unit @ \$14.63 X 18 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$263.34
06-27-05, 06-30-05, and 07-06-05	97110 (1 unit @ \$33.56 X 2 units = \$67.12 X 3 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$201.36
07-07-05 to 08-29-05	97110 (1 unit @ \$33.56 X 3 units = \$100.68 X 16 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,610.88
08-31-05	97110 (1 unit @ \$33.56 X 5 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$167.80

08-08-05, 08-09-05, 08-15-05, 08-23-05, 08-24-05 and 08-31-05	99212 (\$45.26 X 6 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$271.56
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Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
08-23-05 and 08-24-05	97124 (1 unit @ \$26.63 X 2 DOS)(see note below)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$0.00
08-23-05 and 08-24-05	97140 (1 unit @ \$31.79 X 2 units X 2 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$127.16
09-07-05	99213	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$61.89
	Note: CPT code 97124 is global to CPT code 97140 billed on the same dates of service. No reimbursement is recommended.		
	TOTAL DUE		\$2,703.99

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 06-29-06, Medical Dispute Resolution 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 billed for dates of service 06-17-05, 06-20-05, 06-22-05, 06-27-05, 06-30-05, 07-06-05, 07-07-05, 07-11-05, 07-18-05, 07-19-05, 07-25-05, 07-27-05, 08-01-05, 08-03-05, 08-05-05, 08-08-05, 08-09-05, 08-15-05, 08-29-05 and 08-31-05 was denied by the Respondent with denial codes "97" (payment is included in the allowance for another service/procedure) or "B15" (payment adjusted because this procedure/service is not paid separately). Per 134.202 CPT code 97140 is "a mutually exclusive procedure" of CPT code 97012 which was billed on the same dates of service. In order to differentiate between services a modifier is allowed and separate payment for the services billed is considered justifiable if used appropriately, however, CPT code 97140 was not billed with a modifier, therefore, no reimbursement is recommended.

CPT code 97124 billed for date of service 06-17-05 was denied by the Respondent with denial code "97" (payment is included in the allowance for another service/procedure). Per Rule 134.202 CPT code 97124 is considered to be a "component procedure" of code 97140 billed on the same date of service. In no circumstances is a modifier appropriate and the services in the code combination will not be paid separately. No reimbursement recommended.

CPT code 97032 was listed on the Table of Disputed Services for date of service 07-06-05, however, review of the CMS 1500 revealed that code 97032 was not billed on this date of service, therefore, per Rule 134.202 Medical Dispute Resolution will not review this code.

CPT code 99080-73 billed for date of service 08-31-05 was denied by the Respondent with denial code (TWCC 73 not properly completed or submitted in excess of the filing requirements; reimbursement denied per Rule 129.5). The Requestor did not submit documentation for review. No reimbursement recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.1 and 134.202
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 \$2,703.99. 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:

10-13-06

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.

ZRC MEDICAL RESOLUTIONS

August 17, 2006

Re: MDR #: M5 06 1743 01 Injured Employee: ___
DWC #: ___ DOI: ___
IRO Cert. #: 5340 SS#: ___

TRANSMITTED VIA FAX TO:

TDI, Division of Workers' Compensation

Attention: ___

Medical Dispute Resolution

Fax: (512) 804-4868

RESPONDENT: Texas Mutual
TREATING DOCTOR: Alex Flores, DC

In accordance with the requirement for DWC to randomly assign cases to IROs, DWC assigned this case to ZRC Medical Resolutions for an independent review. ZRC has performed an independent review of the medical records to determine medical necessity. In performing this review, ZRC 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 president of ZRC Medical Resolutions, Inc. and I certify that the reviewing physician 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. Your case was reviewed by a Doctor of Chiropractic who is currently listed on the DWC Approved Doctor List.

This decision by ZRC Medical Resolutions, Inc. 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, 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.

Sincerely,
Jeff Cunningham, DC
President

REVIEWER'S REPORT
M5 06 1743 01

Information Provided for Review:

1. DWC Assignment
2. Carrier records
3. Treating doctor records
4. Diagnostic reports

Clinical History:

Mr. ___ was injured on his job when he fell from a scaffolding about 6 feet to the ground and sustained low back injuries on ____. He had a gradual onset of low back pain after the injury. A MRI was performed on his low back which demonstrated a disc bulge at L5/S1 as well as an artifact in the S1/S2 region, which was of unknown origin. An FCE was performed on August 17, 2005 by Alex Flores, DC and the patient was generally classified as being in the light working category, which is below his job requirements. The treating clinic utilized active and passive therapies along with chiropractic manipulation to help return this patient to work.

Disputed Services:

The carrier has denied the medical necessity of manual therapy, therapeutic exercises, self care management training, DME, ultrasound, office visits and massage therapy.

Decision:

I DISAGREE IN PART AND AGREE IN PART WITH THE DETERMINATION MADE BY THE UTILIZATION REVIEW AGENT ON THIS CASE.

THERE IS NO REASONABLE EXPLANATION FOR THE NECESSITY OF THE DME AND SELF CARE MANAGEMENT TRAINING. ALL OTHER CARE IS RENDERED REASONABLE.

Rationale:

The care rendered on this case was generally reasonable. The treating clinic indicated that the patient was indeed in needed of both passive and active care through its documentation. The patient made what appeared to be good progress with the treatment rendered during this period of time it is found that the care was reasonable and necessary, with the exception of the DME and the self-care training, which are not well documented as to their necessity.

Screening Criteria/Literature:

TCA Guidelines, Guidelines of the Mercy Conference