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: Carl M. Naehritz III, D. C. 2900 Hwy 121, Suite 120 Bedford, TX 76021	MDR Tracking No.: M5-06-1752-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: , Box 03	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary states in part, "…Per Rule 408.021(a), all treatments were medically necessary, it cures or relieves the effects naturally resulting from the injury; promotes recovery; or enhances the ability to return to or retain employment…."

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: DOS 6-22-04 -The provider failed to include the EOB (which we have included) which reflects payment for other procedures, including an office visit for this date of service. On the original bill, audited 7-14-05, procedure code 97530 had not been paid, so CMI authorized additional payment which is reflected on the second EOB. Per CCI edits procedure code 98931 is global to 99213 and 99530. We have included a print out from CCI edits. DOS-8-24-05 – Per CMS guidelines, CPT code 99071 is not a payable code, therefore, no reimbursement is allowed. DOS 9-7-05 - Per CMS guidelines, CPT code 99358 is not a payable code, therefore, no reimbursement is allowed."

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. CMS-1500's
3. 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)
6-8-05 – 3-31-06	A9150, 97112, 97140, 97530, 97110, 99358, E0190, A4595, 98941, 99372	☐ Yes ☒ No	$0.00

P.O. Box 855
Sulphur Springs, TX 75483
903.488.2329 * 903.642.0064 (fax)

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 disputed medical necessity issues.

The Requestor sent a revised Table of Disputed Services on 6-23-06. This Table will be used for this review. CPT code 99080-73 on 1-8-05 was withdrawn by the Requestor in a letter dated 8-7-06. HCPCS code E0100 on 12-20-05 was withdrawn by the Requestor in a letter dated 8-30-06. These services will not be a part of this review.

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 6-23-06 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 95831-MT on 6-22-05 was denied by the Respondent as "4-The procedure code is inconsistent with the modifier used or a required modifier is missing," and "W4-No additional reimbursement recommended." Per Rule 134.202(e)(9) "MT" is not an appropriate modifier for this service. Recommend no reimbursement.

CPT code 99071 on 8-24-05 was denied by the Respondent as "97-global" and "W4-No additional reimbursement recommended." Per Rule 134.202(b) this service is "status B" and is not paid separately. Recommend no reimbursement.

CPT code 99358-22 on 9-7-05 was denied by the Respondent as "97-global" and "W4-No additional reimbursement recommended." Per Rule 134.202(e)(2) "22" is an inappropriate modifier for this service. Per Rule 134.202 this service must be listed "separately in addition to code(s) for other physician service(s) and/or inpatient or outpatient Evaluation and Management service." Per the CMS 1500 submitted by the Requestor, no other Evaluation and Management service was performed on the same date of service. Recommend no reimbursement.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

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

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 Division has determined that the Requestor is not entitled to a refund of the IRO fee and is not entitled to reimbursement for the services involved in this dispute.

Findings and Decision and Order by:

	Medical Dispute Officer	9-14-06
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.

INDEPENDENT REVIEW INCORPORATED

August 4, 2006

Re:	**MDR #:**	**M5 06 1752 01**	**Injured Employee:**	___
	DWC #:	___	**DOI:**	___
	IRO Cert. #:	**5055**	**SS#:**	___

TRANSMITTED VIA FAX TO:
TDI, Division of Workers' Compensation
Attention:
Medical Dispute Resolution
Fax: (512) 804-4868

RESPONDENT: **CMI Barron**

REQUESTOR: **Carl Naehritz, DC**

TREATING DOCTOR: **Carl Naehritz, DC**

In accordance with the requirement for DWC to randomly assign cases to IROs, DWC assigned this case to IRI for an independent review. IRI has performed an independent review of the medical records to determine medical necessity. In performing this review, IRI 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 office manager of Independent Review, 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 Doctor of Chiropractic who is currently listed on the DWC Approved Doctor List.

This decision by Independent Review, 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,

jc

Jeff Cunningham, DC
Office Manager

INDEPENDENT REVIEW INCORPORATED

REVIEWER'S REPORT
M5 06 1762 01

Information Provided for Review:

1. DWC Assignment
2. Carrier records
3. Treating doctor records (including MRI and other tests)

Clinical History:

The patient in question was injured on her job when she fell down a group of stairs at her workplace. Injured areas include the right knee, neck and low back. MRI revealed severe chondromalacia patella, degenerative joint disease and a radial tear on the right knee. Lumbar MRI demonstrated a small protrusion at L4/5 and the cervical MRI was positive for a small protrusion at C5/6. The patient underwent initial treatment at Care Now, later switching to the offices of Dr. Carl Naehritz. Records indicate that the patient was treated with physical medicine at Texas Back Care from October of 2004 through March of 2006.

Disputed Services:

The carrier has denied the medical necessity of neuromuscular re-education, manual therapy, nonprescription drugs, therapeutic activities, therapeutic exercises, prolonged evaluation and management, positioning pillow/pillow wedge, TENS supplies, chiropractic manipulation and phone calls from June 8, 2005 through March 13, 2006.

Decision:

I AGREE WITH THE DETERMINATION MADE BY THE UTILIZATION REVIEW AGENT ON THIS CASE.

Rationale:

This case was very well documented by all parties involved, but unfortunately for the requestor there is no indication that the treatment was medically necessary for this patient. There are dozens of office visits that are documented as SOAP notes, but much of this is not legible and the notes do not demonstrate medical necessity for this case. The care that is in dispute has not been demonstrated to have helped this patient to return to work in a productive environment and the use of extended care such as this patient

received has not been validated by literature as necessary and no guidelines that can be found are indicative that such treatment is beneficial to the patient.

Screening Criteria/Literature Utilized

TCA Guidelines, Guidelines of the Mercy Conference.