



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: Valley Spine Medical Center 5327 South McColl Road Edinburg, Texas 78539	MDR Tracking No.: M5-06-1761-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  Rep Box # 29	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 Respondent did not submit a Position Summary to MDR.

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)
07-22-05	E1399	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$15.00
7-28-05 to 8-22-05	97140 (1 unit @ \$31.79 X 7 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$222.53
07-29-05	99080-73	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$15.00
08-05-05 & 08-09-05	97110 (1 unit @ \$33.56 X 2 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$67.12
08-10-05 to 08-22-05	97110 (1 unit @ \$33.56 X 2 units = \$67.12 X 6 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$402.72
07-28-05 to 08-22-05	99212-25 & 99215-25	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
08-24-05 to 11-01-05	99212-25, 97110, 97140, 99080-73, 97750-FC, 99213-25 G0283 and 99213	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
07-22-05	97535	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$35.00
09-22-05	96150	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
<b>TOTAL DUE (MEDICAL NECESSITY)</b>			<b>\$757.37</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, 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 07-10-2006, 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 99213 billed for date of service 12-01-05 was denied by the Respondent with denial code "B7" (this provider was not certified/eligible to be paid for this procedure/service on this date of service). The provider of the service was on DWC's ADL (Approved Doctor List) on the date of service 12-01-05. Reimbursement is recommended in the amount of **\$61.89**.

CPT code 99080-73 billed for date of service 12-01-05 was denied by the Respondent with denial code "B7" (this provider was not certified/eligible to be paid for this procedure/service on this date of service). The provider of the service was on DWC's ADL (Approved Doctor List) on the date of service 12-01-05. Reimbursement is recommended in the amount of **\$15.00**.

**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 \$834.26. 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.

Order by:

11-02-06

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

August 16, 2006  
Amended: August 18, 2006  
Amended: October 26, 2006

**ATTN: Program Administrator**  
**Texas Department of Insurance/Workers Compensation Division**

7551 Metro Center Drive, Suite 100  
Austin, TX 78744  
Delivered by fax: 512.804.4868

## Notice of Determination

MDR TRACKING NUMBER: M5-06-1761-01  
RE: Independent review for \_\_\_\_\_

The independent review for the patient named above has been completed.

- Parker Healthcare Management received notification of independent review on 7.10.06.
- Faxed request for provider records made on 7.10.06.
- The case was assigned to a reviewer on 7.27.06.
- The reviewer rendered a determination on 8.15.06.
- The Notice of Determination was sent on 8.16.06.

The findings of the independent review are as follows:

### Questions for Review

Medical necessity of CPT codes OV- (99212-25/99213/99213-25/99215-25); (97110)-therapeutic exercises; (97140)-manual therapy; (99080-73)-special reports; (G0283)- E-Stim; (97750-FC)-FCE, self care management training (97535), health and behavior assessment (96150) and (E1399)-unlisted DME....Dates in Dispute are 7.22.05-12.1.05

### Determination

PHMO, Inc. has performed an independent review of the proposed care to determine if the adverse determination was appropriate. After review of all medical records received from both parties involved, the PHMO, Inc. physician reviewer has determined to **overturn the denial** on the disputed services service(s): (97110) - therapeutic exercises; (97140) - manual therapy; (99080-73) – special reports; (97535) - self care management training; and (E1399) -unlisted DME that occurred between 7.22.05 through 8.22.05.

The PHMO, Inc. physician reviewer has also determined to **uphold the denial** on all of the disputed services: (99212-25/99213/99213-25/99215-25) –Office Visits; (96150) - health and behavior assessment and (97750-FC)- FCE that occurred between 7.22.05-12.1.05.

The denial is also **upheld** on the disputed services: (97110) - therapeutic exercises; (97140) – manual therapy; (99080-73) – special reports and (G0283) – electrical stimulation that occurred between 8.23.05 through 12.1.05.

### Summary of Clinical History

After sustaining injury to the right knee on \_\_\_\_, the claimant underwent arthroscopy on 7.12.05 and post-operative rehabilitation.

### Clinical Rationale

Physical medicine is an accepted part of a rehabilitation program following surgery. Therefore, the 97110 - therapeutic exercises; 99080-73 – special reports; E1399 – unlisted DME; 97140 – manual therapy; 97535 - self care management training and G0283 – electrical stimulation during the 4-week period from 7.22.05 through 8.22.05 were medically necessary.

However, expectation of improvement in a patient's condition should be established based on success of treatment. Continued treatment is expected to improve the patient's condition and initiate restoration of function. If treatment does not produce the expected positive results, it is not reasonable to continue that course of treatment.

In this case, there is no documentation of objective or functional improvement in this patient's condition and thus no basis to continue the treatment beyond the 4-week period. In fact, there is no evidence that the patient's pain was relieved since no pain ratings were taken; no evidence that recovery was promoted since no examinations were performed before or immediately after the disputed care; and no evidence that there was an enhancement of the claimant's ability to return to work. The lack of benefit to patient is also evidenced by the fact that the patient entered a work hardening program on 10.05.05. Therefore, the disputed treatment after 08.22.05 did not meet statutory requirements 1 for medical necessity.

Specifically in regard to the office visits and based on CPT 2, there is no support for the medical necessity for these E/M services (99212-25, 99213, 99213-25, 99215-25) on most every visit during an established treatment plan.

## Clinical Criteria, Utilization Guidelines or other material referenced

See footnotes listed below for references utilized in this determination.

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The reviewer for this case is a doctor of chiropractic peer matched with the provider that rendered the care in dispute. The reviewer is engaged in the practice of chiropractic on a full-time basis.

The review was performed in accordance with Texas Insurance Code 21.58C and the rules of Texas Department of Insurance /Division of Workers' Compensation. In accordance with the act and the rules, the review is listed on the DWC's list of approved providers or has a temporary exemption. The review includes the determination and the clinical rationale to support the determination. Specific utilization review criteria or other treatment guidelines used in this review are referenced.

The reviewer signed a certification attesting that no known conflicts-of-interest exist between the reviewer and the treating and/or referring 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. The reviewer also attests that the review was performed without any bias for or against the patient, carrier, or other parties associated with this case.

### 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.

I hereby verify that a copy of this Findings and Decision was faxed to Texas Department of Insurance /Division of Workers Compensation applicable to Commission Rule 102.5 this 16<sup>th</sup> day of August, 2006. The Division of Workers Compensation will forward the determination to all parties involved in the case including the requestor, respondent and the injured worker.

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Meredith Thomas  
Administrator  
Parker Healthcare Management Organization, Inc.

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<sup>1</sup> Texas Labor Code 408.021

<sup>2</sup> CPT 2004: *Physician's Current Procedural Terminology, Fourth Edition, Revised*. (American Medical Association, Chicago, IL 1999),