



## 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

Requestor's Name and Address:

David Griffith, D.C.  
800 Dolorosa #400  
San Antonio, TX 78207

MDR Tracking No.: M5-06-2078-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:

Texas Mutual Insurance Company Box 54

Date of Injury:

Employer's Name:

Insurance Carrier's No.: 99F0000419787

#### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: Per the Table of Disputed Services these services were "medically necessary."

Principle Documentation:

1. DWC 60/Table of Disputed Services
2. CMS 1500's

Explanation of Benefits

#### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: 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)
08/22/05 – 02/17/06	99032-59, 97035-59, 97110-GP, 99212-59 99213-25, 99214-25	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
	TOTAL DUE		\$0.00

#### 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.

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 11/30/06 the Requestor submitted an Amended Table of Disputed Services to MDR, which will be used in this MDR Decision.

On 08/30/06, 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 99080-73, billed for date of service 01/19/06 was denied by Respondent with denial code "W1" (Workers Compensation State Fee Schedule Adjustment), denial code "248" DWC-73 not properly completed or submitted in excess of the filing requirements; reimbursement denied per rule 129.5), "W4" (No additional reimbursement allowed after review of appeal/reconsideration), and "891" (The insurance company is reducing or denying payment after reconsideration). Per Rule 129.5 (d)(3), the DWC-73 report shall not exceed one report every two weeks, Requestor submitted DWC-73s on 01/19/06 and on 02/17/06, which complies with this rule requirement. Reimbursement is recommended per Rule 129.5(i) in the amount of **\$15.00**.

CPT Code 99080-73, billed for date of service 02/17/06 was denied by Respondent with denial codes "B7" (This provider was not certified to be paid for this procedure/service on this date of service), "16" (Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate), "225" (The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.), and "287" (This service is denied because the doctor is not on the Texas Approved Doctors List (ADL) for this date of service). MDR verified that the Provider was on the DWC approved doctor's list at the time services were rendered, and documentation requirements were met. Reimbursement is recommended per Rule 129.5(i) in the amount of **\$15.00**.

CPT Code 97110-GP, billed for dates of service 01/25/06, and 01/27/06, was paid by Respondent, but below MAR. Requestor was due \$100.38, and Respondent paid \$95.82, leaving a balance due of \$4.56 for each date of service. CPT Code 97110-GP, billed for dates of service 01/24/06, 02/01/06, 02/03/06, and 02/06/06, was denied by Respondent with denial codes: "42" (charges exceed our fee schedule or maximum allowable amount, and "790" (This charge was reduced in accordance to the Texas Medical Fee Guideline). However the Respondent also made partial payments of \$95.82 for each date of service.

CPT Code 97110-GP, billed for dates of service 02/15/06, and 02/17/06 was denied by Respondent with denial codes "B7" (This provider was not certified to be paid for this. Procedure/service on this date of service), "62"(Payment denied/reduced for absence of, or exceeded, pre-certification/authorization), "287" (This service is denied because the doctor is not on the Texas Approved Doctors List (ADL) for this date of service) and "930" (preauthorization required, reimbursement denied). MDR verified that the Provider was on the DWC approved doctor's list at the time services were rendered. The Requestor submitted preauthorization letter dated 01/24/06 with pre-authorization number JXH01242P for therapeutic exercises (97110) between 01/24/06 and 02/17/06). Therefore the carrier inappropriately denied the services, but made partial payment in the amount of \$95.82. Reimbursement is recommended per Rule 134.202 (c)(1) in the amount of **\$36.48 (\$33.46 x 3 units = \$100.38 - \$95.82 = \$4.56 x 8 DOS = \$36.48)**

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

28 Texas Administrative Code Sec. 133.308, 134.1, 129.5 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 **\$66.48**. 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:

\_\_\_\_\_, Medical Dispute Officer

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

**IRO Medical Dispute Resolution M5 Retrospective Medical Necessity  
IRO Decision Notification Letter**

<b>Date:</b>	<b>11/01/2006</b>
<b>Injured Employee:</b>	
<b>MDR #:</b>	<b>M5-06-2078-01</b>
<b>DWC #:</b>	
<b>MCMC Certification #:</b>	<b>TDI IRO-5294</b>

**REQUESTED SERVICES:**

Please review the item(s) in dispute: Electrical Stimulation (97032-59), ultrasound (97035-59), therapeutic exercises (97110-GP), office visits (99212-59/99213-25 and 99214-25).

**DECISION: Upheld**

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IRO MCMCIIc (MCMC) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO) to render a recommendation regarding the medical necessity of the above disputed service.

**Please be advised that a MCMC Physician Advisor has determined that your request for an M5 Retrospective Medical Dispute Resolution on 11/01/2006, concerning the medical necessity of the above referenced requested service, hereby finds the following:**

The medical necessity for the course of care captioned above is not established upon review of the submitted clinical information.

**CLINICAL HISTORY:**

Records indicate that the above captioned individual sustained injuries as a result of an occupation incident that allegedly occurred on or about 7/\_\_\_/05. There is no documentation submitted for review, however clinical notes indicate that the injured individual has been administered care from a litany of providers including the current chiropractic AP. Chiropractic care has included a course of both passive and active modalities.

**REFERENCES:**

References utilized in this review may include but are not limited to the ACEOM Guidelines, Official Disability Guidelines, Health Care Guidelines by Milliman and Robertson Volume 7, North American Spine Society Guidelines, Texas Medical Fee Guidelines, and Procedural Utilization Guidelines.

**RATIONALE:**

There was no submitted clinical data or information to support the medical necessity of the above captioned course of care. There are no submitted examination notes or daily notes for the purpose of review. Therefore, it could not be determined what prior care had been attended or what specific response to care to date had been documented. Also, it could not be determined what initial, presenting symptomatology had been documented or recorded information pertaining to the mechanism of injury. As such, in light of the total absence of pertinent medical information, the medical necessity for the above captioned course of care is not established.

**DATES RECORDS RECEIVED:**

None received except for initial documents sent with request for IRO.

**RECORDS REVIEWED**

- Notification of IRO Assignment dated 08/30/06
- MR-117 dated 08/30/06
- DWC-60
- MCMC: IRO Medical Dispute Resolution M5 Retrospective Medical Necessity dated 10/10/06
- MCMC: IRO Acknowledgment and Invoice Notification Letter dated 08/31/06
- Pain & Recovery Clinic of San Antonio: Check dated 09/28/06
- Texas Mutual: Explanation of Benefits dated 09/14/05, 11/08/05 (three), 01/24/06, 02/15/06, 03/06/06, 03/21/06, 04/11/06

**The reviewing provider is a **Licensed/Boarded Chiropractor** and certifies that no known conflict of interest exists between the reviewing Chiropractor 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 prior to referral to the IRO. The reviewing physician is on DWC's Approved Doctor List.**

**This decision by MCMC is deemed to be a Division decision and order (133.308(p) (5)).**

#### **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.

**In accordance with Division rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent via facsimile to the office of DWC on this**  
**1<sup>st</sup> day of November 2006.**

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

**Printed Name of IRO Employee:** \_\_\_\_\_

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