



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 | |
| Requestor's Name and Address: Valley Spine Medical Center 5327 South McColl Road Edinburg, Texas 78539 | MDR Tracking No.: M5-07-0049-01 (current MDR #) M2-06-1906-01 (former MDR #) |
| | Claim No.: |
| | Injured Employee's Name: |
| Respondent's Name and Address: American Home Assurance Company Rep Box # 19 | Date of Injury: |
| | Employer's Name: |
| | Insurance Carrier's No.: |

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: "Attached you will find a dispute for dates of service: 08/29-05 – 11/30/05. The claims were incorrectly reduced. I have included copies of medical records, insurance carrier's explanation of benefits and claims for the dates in question."

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: "It appears that this case has been docketed incorrectly as a prospective dispute opposed to a retrospective dispute. The majority of the attached charges were denied with ANSI "50" which is unnecessary medical."

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) |
|---------------------------------|--|---|--------------------------------|
| 09-06-05 to 11-30-05 | 97110 (1 unit @ \$33.56 X 2 units X 15 DOS) | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$1,006.80 |
| 09-06-05 to 11-30-05 | 97110 (6 units per 15 DOS) | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | \$0.00 |
| 09-01-05 | 97110 (1 unit @ \$33.56 X 2 units)(* see note below) | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$0.00 |
| 09-06-05 to 11-10-05 | 97140 (** see note below) | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$0.00 |
| 11-18-05, 11-21-05 and 11-30-05 | 97140-59 (1 unit @ \$31.79 X 2 units X 3 DOS) | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$190.74 |
| 09-06-05 to 11-10-05 | 97012 (1 unit @ \$17.76 X 10 DOS) | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$177.60 |
| 09-06-05 to 11-30-05 | G0283 (1 unit @ \$13.61 X 15 DOS) | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$204.15 |

| Date(s) of Service | CPT Code(s) or Description | Medically Necessary? | Additional Amount Due (if any) |
|---|--|---|--------------------------------|
| 09-01-05 to 11-30-05 | 97035 (1 unit @ \$14.63 X 16 DOS) | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$234.08 |
| 09-06-05, 09-07-05, 09-09-05, 09-12-05, 11-09-05, 11-18-05, 11-21-05 and 11-30-05 | 99212-25 (\$45.26 X 8 DOS) | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$362.08 |
| 09-29-05 | 99213 | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$61.89 |
| 11-14-05, 11-16-05, 11-18-05, 11-21-05 and 11-30-05 | 97124 (1 unit @ \$26.63 X 5 DOS) | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$133.15 |
| | Note: *The IRO reviewer found 2 units to be medically necessary, the Respondent has already paid for 2 units. No additional reimbursement is recommended. ** The IRO reviewer found the services to be medically necessary, however, CPT code 97140 per Rule 134.202 is mutually exclusive to CPT code 97012 also billed on the dates of service. A modifier is allowed to differentiate between the services and payment may be justifiable. The Requestor did not bill with a modifier therefore no reimbursement is recommended. | | |
| | TOTAL DUE | | \$2,370.49 |

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 10-16-2006, 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 99080-73 date of service 09-29-05 was listed on the Table of Disputed Services. The Requestor was contacted on 11-15-06 and advised Medical Dispute Resolution that this service had been paid. Therefore this service is no longer in dispute.

CPT code 97140 billed for dates of service 08-31-05 and 09-01-05 was denied by the Respondent with denial codes "B15" (payment adjusted because this procedure/service is not paid separately), "434" (per CCI edits, the value of this procedure is included in the value of the mutually exclusive procedure) and "243" (the charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed). Per Rule 134.202 CPT code 97140 is mutually exclusive to CPT code 97012 also billed on dates of service 08-31-05 and 09-01-05. An appropriate modifier if billed is allowed to differentiate between the services and separate payment may be justifiable. The Requestor did not bill with a modifier. No reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.1 and 134.202(c)(1)
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 \$2,370.49. 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:

11-20-06

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.

Clear Resolutions Inc.

An Independent Review Organization

3616 Far West Blvd. Suite 337-117

Austin, TX 7831

Amended November 15, 2006

November 10, 2006

TDI-DWC Medical Dispute Resolution

Fax: (512) 804-4868

Delivered via Fax

Patient / Injured Employee

TDI-DWC #:

MDR Tracking #:

IRO #:

_____ M5-07-0049-01

5327

Clear Resolutions, Inc. has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI-Division of Worker's Compensation (DWC) has assigned this case to Clear Resolutions for independent review in accordance with DWC Rule 133.308 which allows for medical dispute resolution by an IRO.

Clear Resolutions has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Provider board certified and specialized in Chiropractic Care. The Reviewer is on the DWC Approved Doctor List (ADL). The Clear Resolutions Panel Member/Reviewer is a health care professional who has signed a certification statement stating that no known conflicts of interest exist between the Reviewer 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 carriers health care providers who reviewed the case for decision before referral to IRO America for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

RECORDS REVIEWED

Notification of IRO assignment, information provided by The Requestor, Respondent, and Treating Doctor(s), including but not limited to:

- 22-pages MDR Request
- TWCC-73 dated 8-31-05, 9-29-05
- Lumbar MRI dated 9-2-05
- 3-pages Initial Exam report Dr. Alex Flores dated 7-27-05
- Subsequent Medical report Dr. Alex Flores dated 8-24-05
- Initial Medical Report Dr. Gerardo Zavala dated 9-16-05
- Initial FCE dated 9-20-05
- Follow-up Evaluation Dr. Gerardo Zavala dated 10-14-05, 10-28-05, 11-11-05, 11-28-05, 12-9-05, 1-27-06, 2-24-06, 4-7-06, 6-22-06, 7-21-06
- Interim FCE dated 2-9-06
- Daily SOAP notes dated 8-29-05, 8-31-05, 9-1-05, 9-6-05, 9-7-05, 9-9-05, 9-12-05, 9-14-05, 9-15-05, 9-29-05, 11-8-05, 11-9-05, 11-10-05, 11-14-05, 11-18-05, 11-16-05, 11-21-05, 11-29-05

CLINICAL HISTORY

The Patient was injured while working for . On ____, she was working in the deli department and was carrying a box of chicken, when she heard a loud pop. She had immediate pain in her low back and could not elevate her arms over her head. On 7-27-2005, she sought treatment with Valley Spine Medical Center, where she was evaluated, taken off work, and placed into physical therapy. On 9-02-2005, MRI of the lumbar spine revealed a 2mm disc bulge at L5-S1. On 10-28-2005, 11-11-2005, and 11-28-2005, LESI were performed. The Patient underwent additional therapy from 9-01-2005 through 11-30-2005.

DISPUTED SERVICE (S)

Under dispute is the retrospective medical necessity of 97035-Ultrasound, 97110-Therapeutic Exercise, 97140-Manual Therapy Technique, 97012-Mechanical Traction, G0283-Electrical Stim, 99212-25-Est E/M OV, 99213-Ov, 99080-73 Special report, 97124-Massage therapy, 97140-59-Manual Therapy technique for the dates 8/29/05 through 11/30/05.

DETERMINATION / DECISION

The Reviewer partially agrees with the determination of the insurance carrier. The Reviewer disagrees with the insurance carrier on all services except the 97110-Therapeutic Exercises. The Reviewer's conclusion is that only 2 units from the 8 that were billed for every 97110-Therapeutic Exercises were medical necessary. The Reviewer agrees with the insurance carrier that 6 units were not medically necessary and 2 disagrees with the insurance carrier that 2 units were medically necessary for every 97110-Therapeutic Exercise.

RATIONALE/BASIS FOR THE DECISION

Based on the clinical evidence and documentation, the Reviewer concluded that the disputed services were partially medically necessary. The Reviewer agrees that only 2 units of 97110-therapeutic exercise would be considered medically and that 6 units of 97110-therapeutic exercise would not be considered medically.

The patient has a small 2mm disc bulge at L5-S1. The patient underwent LESI during some of the therapy dates that are in question; therefore, post LES therapy is usually considered as reasonable and medically necessary according to the medical standards. The patient did progress through treatment.

Screening Criteria

General:

In making his determination, the Reviewer had reviewed medically acceptable screening criteria relevant to the case, which may include but is not limited to any of the following: Evidence Based Medicine Guidelines (Helsinki, Finland); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Texas Chiropractic Association: Texas Guidelines to Quality Assurance (Austin Texas); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Mercy Center Guidelines of Quality Assurance; any and all guidelines issued by DWC or other State of Texas Agencies; standards contained in Medicare Coverage Database; ACOEM Guidelines; peer-reviewed literate and scientific studies that meet nationally recognized standards; standard references compendia; and findings; studies conducted under the auspices of federal government agencies and research institutes; the findings of any national board recognized by the National Institutes of Health; peer reviewed abstracts submitted for presentation at major medical associates meetings; any other recognized authorities and systems of evaluation that are relevant.

CERTIFICATION BY OFFICER

Clear Resolutions has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Clear Resolutions has made no determinations regarding benefits available under the injured employee's policy.

As an officer of Clear Resolutions Inc., I certify that there is no known conflict between the Reviewer, Clear Resolutions and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Clear Resolutions is forwarding by mail or facsimile, a copy of this finding to the DWC.

Sincerely,

Chris Crow
President & Chief Resolutions Officer

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. 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.

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

I hereby certify, in accordance with DWC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent DWC via facsimile, U.S. Postal Service or both on this 10th day of November, 2006.

Name and Signature of Clear Resolutions Inc. Representative:

Sincerely,

Chris Crow
President & Chief Resolutions Officer