



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 Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier

Requestors Name and Address: Paul Raymond, D. C. 8200 Wednesburg Lane, Suite 210 Houston, TX 77074	MDR Tracking No.: M5-07-0447-01 Previous Tracking No.: M4-05-9772-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: UTICA MUTUAL INSURANCE CO, BOX 01	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary states, "The clinical facts presented by this facility strongly supports our position that the treatment rendered at this office was not only medically necessary but it will promote case resolution pursuant Labor Code 408.021."

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 (e-mail of 1-31-07) states that the Respondent has no additional information to provide.

1. CMS-1500's
2. EOB's
3. Medical records

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)
11-05-04 – 2-25-05	97032 (\$20.04 x 13 units - <MAR for 2-3-05 – 2-25-05)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$260.52
11-05-04 – 11-24-04	97035 (\$15.78 x 18 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$284.04

2-3-05 – 2-25-05	97140 (\$33.91 < MAR x 6 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$203.46
	Total Due		\$748.02

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 disputed medical necessity issues. Per Rule 134.202 (c)(1) and (d)(2) the amount due the Requestor for the items denied for medical necessity is \$748.02.

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.

In a letter dated 2-8-07 CPT code 97139 and HCPCS code A4556 were withdrawn by the Requestor. These services will not be a part of this review.

On 6-28-05 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 99070 on 11-5-04 was denied by the Respondent as "W1 (04) – The procedure, material or service is not normally charged," and as "N-Not documented." Per Rule 134.202(b) this service is "Bundled" and can not be reimbursed separately. The Requestor did not document this service in the medical notes.

Regarding CPT code 97018 from 11-08-04 through 11-24-04: This service was denied by the Respondent as "G-Unbundling" and as "W1-Z3-The procedure, which is the component code is considered integral to the successful completion of the comprehensive procedure. The procedure does not represent a separately identifiable unrelated procedure." Per Rule 134.202(b) this service is a component procedure of CPT code 97140. A modifier is allowed in order to differentiate between the services provided. No modifier was billed by the Requestor. Recommend no reimbursement.

CPT code 97032 from 11-29-04 through 1-26-05 was denied by the Respondent on both the initial and reconsideration EOB's as "RC MU – Physical medicine and rehabilitation services may not be reported in conjunction with an evaluation and management code performed on the same day." Per Rule 134.202(b) this service is not a component service of any other service performed on this date. Recommend reimbursement of \$420.84 (\$20.04 x 21 units) less than MAR for 1-3-05 – 1-26-05. (2004 MAR = \$20.04) (2005 MAR = \$20.34) Billed \$20.04.

CPT code 97035 from 11-29-04 to 12-01-04 was denied by the Respondent on both the initial and reconsideration EOB's as "RC MU – Physical medicine and rehabilitation services may not be reported in conjunction with an evaluation and management code performed on the same day." Per Rule 134.202(b) this service is not a component service of any other service performed on this date. Recommend reimbursement of \$47.34 (\$15.78 x 3 units).

CPT code 97110 from 11-29-04 through 1-26-05 was denied by the Respondent on both the initial and reconsideration EOB's as "RC MU – Physical medicine and rehabilitation services may not be reported in conjunction with an evaluation and management code performed on the same day." Per Rule 134.202(b) this service is not a component service of any other service performed on this date. Recommend reimbursement of \$2,444.64 (\$37.04 x 66 units) less than MAR for 1-3-05 – 1-26-05.

CPT code 97140-59 from 12-01-04 through 1-26-05 (except 12-29-04 – 01-20-05) was denied by the Respondent on both the initial and reconsideration EOB's as "RC MU – Physical medicine and rehabilitation services may not be reported in conjunction with an evaluation and management code performed on the same day." Per Rule 134.202(b) this service is a component service of CPT code 97012 which was billed on this date. However, a modifier is allowed to differentiate the services. The modifier "59" was billed with this code. Recommend reimbursement of \$678.20 (\$33.91 x 20 units).

CPT code 97140 from 12-29-04 – 01-20-05 was denied by the Respondent on both the initial and reconsideration EOB's as "RC MU – Physical medicine and rehabilitation services may not be reported in conjunction with an evaluation and management code performed on the same day." Per Rule 134.202(b) this service is a component of CPT code 97012 which was billed on this date. A modifier is allowed to differentiate the services. No modifier was billed in order to differentiate the services. Recommend no reimbursement.

CPT code 97012 from 12-01-04 through 1-26-05 was denied by the Respondent on both the initial and reconsideration EOB's as "RC MU – Physical medicine and rehabilitation services may not be reported in conjunction with an evaluation and management code performed on the same day." Per Rule 134.202(b) this service is not a component of any other service performed on this date. Recommend reimbursement of \$380.40 (\$19.10 x 12 units + \$18.90 x 8 units).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

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

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 Respondent must refund the amount of the IRO fee (\$460.00) to the Requestor within 30 days of receipt of this order. The Division has determined that the Requestor is entitled to reimbursement in the amount of \$4,719.44. 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.

Findings and Decision and Order by:

Authorized Signature

Typed Name

02-22-07

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.

SENT TO: Texas Department of Insurance
Health & Workers' Compensation Network Certification & QA
Division (HWCN) MC 103-5A
Via fax: 512.804.4868

January 18, 2007

RE: IRO Case #: M5 07 0447 01
Name: _____
Coverage Type: Workers' Compensation Health Care - Non- network
Type of Review:
____ Preauthorization
____ Concurrent Review
 X Retrospective Review
Prevailing Party:
 X Requestor
____ Carrier

ZRC Medical Resolutions, Inc. (ZRC) has been certified, IRO Certificate 5340 by the Texas Department of Insurance (TDI) as an Independent Review Organization (IRO). TDI has assigned this case to ZRC for independent review in accordance with the Texas Insurance Code, the Texas Labor Code and applicable regulations.

ZRC has performed an independent review of the proposed/rendered care to determine if the adverse determination was appropriate. In the performance of the review, ZRC reviewed the medical records and documentation provided to ZRC by involved parties.

This case was reviewed by a chiropractor. The reviewer 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 (URA), and any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO.

In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

As an officer of ZRC, I certify that:

1. there is no known conflict between the reviewer, ZRC and/or any officer/employee of ZRC with any person or entity that is a party to the dispute, and
2. a copy of this IRO decision was sent to the DWC via fax service or otherwise transmitted in the manner indicated above on January 18, 2007.

RIGHT TO APPEAL:

You have the right to appeal the decision by seeking judicial review. This IRO decision is binding during the appeal process.

For disputes other than those related to prospective or concurrent review of spinal surgery, the appeal must be filed:

1. directly with a district court in Travis County (see Labor Code 413.031(m)), and
2. within thirty (30) days after the date on which the decision is received by the appealing party.

Sincerely,

Jeff Cunningham, D.C.
President/CEO

**REVIEWER'S REPORT
M5 07 0447 01**

Brief Clinical History: Patient is a 42-year-old male warehouse worker who, on ___ injured his neck, upper back and right wrist after he repeatedly moved inventory boxes weighing between five and fifty pounds each. The records submitted further related that on that date, he repeatedly hoisted the boxes onto his right shoulder, and then carried them in that fashion. Following this activity, he developed "intolerable" pain in the right regions of his neck and upper back, with frequent shooting pains into his right wrist and hand. He presented the following day () for evaluation and treatment. An MRI of the claimant's cervical spine was immediately performed (also) and it revealed a posterolateral bilateral 2-3mm discal protrusion/herniation that contributed to narrowing of the foramen on each side; this finding was superimposed on a broad posterior 1-2mm annular disc bulge that abutted the anterior thecal sac.

Item(s) and Date(s) in Dispute: Electrical stimulation, attended (97032), ultrasound therapy (97035), and manual therapy technique (97140) for dates of service 11/5/04 through 2/25/05.

Decision: The position of the carrier is overturned as the treatment in dispute is approved.

Rationale/Basis for Decision: In this case, the medical records submitted adequately documented that the claimant had sustained an injury to his cervical spine and that he was experiencing radicular symptoms as a result his injury. Therefore, a conservative trial of chiropractic care and physical therapy was supported as medically necessary.

Furthermore, the medical records adequately documented that the care rendered in this case fulfilled the statutory requirements¹ for medical necessity, since the patient obtained relief, promotion of recovery was accomplished and there was an enhancement of the injured employee's ability to return to his pre-injury employment.

Screening Criteria/Treatment Guidelines: Texas Labor Code/Mercy Center Guidelines/TCA Guidelines

¹ Texas Labor Code 408.021