



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

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address: Clem C. Martin, D. C. 207 E. 6 th Street Bonham, TX 75418	MDR Tracking No.: M5-06-0348-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Lumbermen's Mutual Casualty Company, Box 42	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include DWC-60 form, Explanations of Benefits, medical documentation and CMS 1500's. Position Summary (Table of Disputed Services) states, "Denials unsupported by medical rationale."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No position summary was received.

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)
12-3-04, 1-25-05, 2-15-05, 4-26-05, 6-18-05	CPT code 99213-25 (\$48.00 X 5 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$240.00
4-19-05	CPT code 99212	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$36.00
11-15-04, 12-3-04, 12-6-04, 12-7-04, 1-6-05, 1-7-05, 1-10-05, 1-14-05, 1-25-05, 2-15-05, 2-21-05, 3-4-05, 3-23-05, 6-17-05	CPT code 98940 and 98940-59 (\$30.63 X 14 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$428.82
11-5-04 – 6-22-05	CPT codes 92531, 92532, 98940, 98941, 97010, 99080, 94760, 99213, 99214, 97140, 97112, and 99050 except as noted above	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0

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. The total amount owed the requestor for the medical necessity issues is \$704.82.

Rule 134.202 (b) states that Texas Workers' Compensation system participants shall apply the Medicare program reimbursement coding, billing, and reporting payment policies in effect on the date a service is provided. Rule 133.1(a)(3)(C) states that a complete medical bill includes correct billing codes from Commission fee guidelines in effect on the date of service. The requestor billed codes 97140-22, 92531-25, 92532-25, 94760-25, 97112-25 from 11-15-04 – 6-22-05. These modifiers are invalid with these codes after 8-1-03. The requestor will be billed for using invalid modifiers.

CPT code 97010 is a bundled service code and considered to be an integral part of a therapeutic procedure(s). Reimbursement for code 97010 is included in the reimbursement for the comprehensive therapeutic code.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 134.202 (b).

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 entitled to additional reimbursement totaling \$704.82 for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

Donna Auby

01-03-06

Authorized Signature

Typed Name

Date of Findings and Decision

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.



Specialty Independent Review Organization, Inc.

Amended Report of 12/23/05

December 6, 2005

DWC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient: ____
DWC #: ____
MDR Tracking #: M5-06-0348-01
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The Division of Workers' Compensation has assigned this case to Specialty IRO for independent review in accordance with DWC Rule 133.308, which allows for medical dispute resolution by an IRO.

Specialty IRO has performed an independent review of the care rendered 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.

This case was reviewed by a licensed Chiropractor. The reviewer is on the DWC ADL. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

____ was injured on ____ while she was employed by Altria Group Inc. The records indicate she was injured when she bent over to clean out a glue pot. She was treated conservatively throughout the course of care. She underwent manipulations, ESI's, passive therapy, active therapy, medical treatment, MRI's (multiple) and peer reviews. She has not undergone a surgical procedure to this point. Records provided prior to 10/4/04 were very minimal.

RECORDS REVIEWED

Records were received from the treating doctor/requestor. Records were requested from the respondent but not received. Records from the requestor include the following: rationale for treating physician intervention letter by Dr. Martin, TWCC 61, 10/14/96 lumbar MRI, 10/14/96 MRI addendum, 1/10/97 lumbar MRI, 6/24/02 lumbar MRI, handwritten note of B. McMaster exam, 11/22/05 letter from Mathew Martin, 6/20/02 preauth request authorization for lumbar MRI, 8/1/05 request for recon, HICFA 1500's of multiple dates, handwritten SOAP notes from 10/5/04 to 6/22/05, various/multiple EOB's, 4/27/05 request for recon, 11/15/04 through 2/15/05 Static Tests, RME report by B. McMaster, MD and 4/27/05 request for recon letter.

DISPUTED SERVICES

Disputed services include the following: 92531-25, 92532-25, 98940, 98940-59, 98941, 98943, 97010, 99080, 94760, 94760-25, 99212 (-25), 99213-25, 99214-25, 97140-22, 97112, 97112-22, 99080 and 99050 from 11/15/04 through 06/22/05.

DECISION

The reviewer disagrees with the previous adverse determination regarding the following codes on the following dates: **99213-25** (12/03/04, 01/25/05, 2/15/05, 4/26/05, 6/18/05), **99212** (4/19/05) and **98940** (on 11/15/04, 12/03/04, 12/6/04, 12/7/04, 1/6/05, 1/7/05, 1/10/05, 1/14/05, 1/25/05, 2/15/05, 2/21/05, 3/4/05, 3/23/05, 6/17/05).

The reviewer agrees with the previous adverse determination regarding all remaining services on all remaining dates.

BASIS FOR THE DECISION

Positional and spontaneous nystagmus testing and noninvasive ear/pulse oximetry were not medically necessary as a separate component to the standard E&M code of this date. This is a portion of the neurological requirement and physical examination requirement respectively. Exacerbations of lumbar pain were noted on or about 11/11/04. The 99214-25 codes were not documented to the level required by the Medicare Fee and Payment Guidelines. Specifically, a detailed history and examination were not documented.

It is not apparent why the patient was seen "after hours" on 6/18/05 as her pain scale had reduced from a 7/10 on 6/17/05 and was down to a 4/10 on 6/18/05. This type of visit is generally utilized when the situation is an emergency. In regards to the manual therapy coding, it is not properly documented as per Medicare Guidelines or TWCC Guidelines. The reviewer is unable to find evidence of copying of records as per code 99080 and section 133.106 of the DWC rules. Regarding codes 98941 and 98943, these codes are not documented as to the standards of the Medicare or TWCC Guidelines. Specifically, the patient complains of back pain only on 4/19/05. There would not appear to be a medical necessity to perform a multi-level spinal manipulation (more than two spinal areas as per the CPT codebook) and/or an extremity manipulation to a patient with the diagnosis codes of 847.2, 728.85 and 724.4.

The treating doctor documented the exacerbations well. He treated the exacerbations appropriately and relieved the patient's pain with the lumbar manipulations; therefore, they are approved (as noted above) as per TLC §408.021 and as per the research of Haas et al.

REFERENCES

[Haas M, Sharma R](#), Stano M. Cost-effectiveness of medical and chiropractic care for acute and chronic low back pain. J Manipulative Physiol Ther. 2005 Oct;28(8):555-63.

Medicare Payment Policies and Guidelines

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that the reviewing provider has no known conflicts of interest between that provider 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 IRO.

Sincerely,

Wendy Perelli, CEO

CC: Specialty IRO Medical Director

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 (other than a spinal surgery prospective 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.

Sincerely,

Wendy Perelli, CEO

I hereby certify, in accordance with TDI/DWC- Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the via facsimile, U.S. Postal Service or both on this 23rd day of December 2005

Signature of Specialty IRO Representative:

Name of Specialty IRO Representative: Wendy Perelli