

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP () IE () IC	Response Timely Filed? (X) Yes () No
Requestor's Name and Address Southeast Health Services P. O. Box 453062 Garland, Texas 75045	MDR Tracking No.: M5-05-2078-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address American Casualty Company of Reading, Box 47	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS – MEDICAL NECESSITY ISSUES

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
4-2-04	4-2-04	CPT codes 98940, 97140-59, 97032, 97016, 97113	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

PART III: 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 Commission Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Medical Review Division 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, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. The services, rendered were found were not found to be medically necessary. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 4-28-05 the Medical Review Division 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.

Regarding CPT code 98940 on 3-29-04: Neither the carrier nor the requestor **provided EOB's**. The req. submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). **Recommend reimbursement of \$33.08.**

Regarding CPT code 98940 on 4-19-04: Neither the carrier nor the requestor **provided EOB's**. The req. submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). **Recommend reimbursement of \$33.08.**

Regarding CPT code 97140-59 on 3-29-04: Neither the carrier nor the requestor **provided EOB's**. The req. submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). The "59 modifier identifies it as a "distinct procedural service". **Recommend reimbursement of \$34.13.**

Regarding CPT code 97140-59 on 3-31-04: Neither the carrier nor the requestor **provided EOB's**. The req. submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). **Recommend reimbursement of \$34.13.**

Regarding CPT code 97113 on 3-29-04 and 3-31-04: Neither the carrier nor the requestor **provided EOB's**. The req. submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). **Recommend reimbursement of \$212.45 (\$42.49 X 5 units).**

Regarding CPT code 97032 on 3-31-04: Neither the carrier nor the requestor **provided EOB's**. The req. submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). **Recommend reimbursement of \$20.20.**

Regarding CPT code 97016 on 3-31-04: Neither the carrier nor the requestor **provided EOB's**. The req. submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). **Recommend reimbursement of \$18.40.**

Regarding CPT code 99212 on 3-31-04: Neither the carrier nor the requestor **provided EOB's**. The req. submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). **Recommend reimbursement of \$48.99.**

PART IV: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to a refund of the paid IRO fee. The Division hereby **ORDERS** the insurance carrier to remit the appropriate amount totaling \$434.46 for the services in dispute consistent with the applicable fee guidelines, plus all accrued interest due at the time of payment, to the Requestor within 20-days of receipt of this Order.

Findings and Decision by:

Donna Auby

7-21-05

Authorized Signature

Typed Name

Date of Order

PART V: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

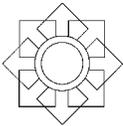
Signature of Insurance Carrier: _____ Date: _____

PART VI: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.



Texas Medical Foundation

Barton Oaks Plaza Two, Suite 200 • 901 Mopac Expressway South • Austin, Texas 78746-5799
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NOTICE OF INDEPENDENT REVIEW DECISION

June 16, 2005

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker: _____
MDR Tracking #: M5-05-2078-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. TMF's health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient was injured on _____. Treatment included vasopneumatic devices, electrical stimulation, aquatic therapy, manual therapy technique, and chiropractic manipulation.

Requested Service(s)

Vasopneumatic devices, electrical stimulation, aquatic therapy, manual therapy technique, chiropractic manipulation for date of service 03/31/04

Decision

It is determined that there is no medical necessity for the vasopneumatic devices, electrical stimulation, aquatic therapy, manual therapy technique, and chiropractic manipulation for date of service 03/31/04 to treat this patient's medical condition.

Rationale/Basis for Decision

Medical record documentation indicates the requested services were performed almost six months after the date of injury. There is not sufficient documentation of treatment, diagnostic testing, or physical examination to confirm the medical necessity of the denied services. Therefore, the vasopneumatic devices, electrical stimulation, aquatic therapy, manual therapy technique, and chiropractic manipulation for date of service 03/31/04 is not medically necessary to treat this patient's medical condition.

Sincerely,

A handwritten signature in black ink that reads "Gordon B. Strom, Jr." The signature is written in a cursive, somewhat stylized font.

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:vn

Attachment

Information Submitted to TMF for TWCC Review

Patient Name: ____

TWCC ID #: M5-05-2078-01

Information Submitted by Requestor:

- Claims

Information Submitted by Respondent:

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