

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP () IE () IC	Response Timely Filed? () Yes (X) No
Requestor's Name and Address Behavioral Healthcare Associates 4101 Greenbriar, Suite 115 Houston, Texas 77098	MDR Tracking No.: M5-05-2144-01
	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

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
4-8-04	4-8-04	CPT codes 90801, 90885, 90889	<input checked="" type="checkbox"/> Yes <input 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 **prevailed** on the disputed medical necessity issues. CPT codes 90801, 90885 and 90889 were found to be medically necessary. Per Ingenix Encoder Pro, CPT code 90885 and CPT code 90889 are bundled codes. However, Ingenix Encoder Pro does not state what code these are bundled with. The Medicare Fee Schedule for CPT codes 90885 and 90889 has no value. Rule 134.202 (c)(6), states, "for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments." Per Rule 134.202 (c) (6), since neither party submitted proof of relative values, no reimbursement for CPT codes 90885 and 90889 can be recommended. **Recommend reimbursement of \$192.58 for CPT code 90801.**

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. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 5-4-05 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.

CPT codes 96150 (4 units), 96152 (4 units) and 96152 (8 units) on 5-20-04 and 5-27-04 were denied as "V – Unnecessary treatment with peer review". In accordance with Rule 134.600 (h) (4), the requestor provided a copy of the preauthorization letters dated 4-26-04 and 5-27-04. The carrier denied these sessions for unnecessary medical treatment based on a peer review. Rule 133.301 (a) states "the insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatments (s) and/or service (s) for which the health care provider has obtained preauthorization under Chapter 134 of this title." Therefore, reimbursement is recommended in the amount of \$509.20 in accordance with Rule 134.600 (b)(1)(B).

PART IV: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to a refund of the paid IRO fee in the amount of \$460.00. The Division hereby **ORDERS** the insurance carrier to remit the amount of \$701.78 plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Donna Auby

7-7-05

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.

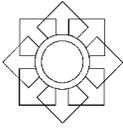
Signature of Insurance Carrier: _____ Date: _____

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
phone 512-329-6610 • fax 512-327-7159 • www.tmf.org

NOTICE OF INDEPENDENT REVIEW DECISION

June 9, 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 #: M5-05-2144-01
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 47 year-old female injured her neck, low back and shoulders on ____ while lifting patients. She was treated with therapy, epidural steroid injections and psychological testing.

Requested Service(s)

Psychiatric diagnostic interview examination, psychiatric evaluation of hospital records, psychiatric report of patient's psychological status for date of service 04/08/04

Decision

It is determined that there is medical necessity for the psychiatric diagnostic interview examination, psychiatric evaluation of hospital records, psychiatric report of patient's psychological status for date of service 04/08/04 to treat this patient's medical condition.

Rationale/Basis for Decision

Psychological evaluations are almost always required before a multi-disciplinary treatment program is authorized. In this case, the psychological evaluation indicated that the patient is not in need of psychological

treatment. This information can now be used by the carrier in making determination of future programs such as

work hardening and work conditioning. Therefore, the psychiatric diagnostic interview examination, psychiatric evaluation of hospital records, and psychiatric report of patient's psychological status for date of service 04/08/04 is medically necessary to treat this patient's medical condition.

Sincerely,



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

GBS:dm

Attachment

Attachment

Information Submitted to TMF for TWCC Review

Patient Name: ____

TWCC ID #: M5-05-2144-01

Information Submitted by Requestor:

- Requestors Position

Information Submitted by Respondent:

Respondents Position