



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: South Coast Spine and Rehab, P. A. 620 Paredes Line Road Brownsville, TX 78521	MDR Tracking No.: M5-05-2165-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Brownsville ISD, Box 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the TWCC 60 package.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the TWCC 60 response.

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)
9-13-04 – 1-27-05	CPT codes 99204, 97750-FC, 99213, 97035, 97124, 97113	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$

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. The amount due the requestor for the items denied for medical necessity is \$4832.27.

CPT code 99080-73 on 9-18-04 and 99080-69 on 11-11-04 were withdrawn by the requestor and will not be a part of this review.

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.

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 99080-73 on 9-18-04 was denied for unnecessary medical treatment; however, the TWCC-73 is a required report per Rule 129.5 and is not subject to an IRO review. A referral will be made to Compliance and Practices for this violation. The Medical Review Division has jurisdiction in this matter; The requestor submitted relevant information to support delivery of service. Recommend reimbursement of \$15.00.

CPT code 99455-WP on 11-11-04 was denied for medical necessity. Per Rule 134.202 (e)(6) this exam is not subject to an IRO review. The requestor billed the exam in accordance with 134.202 (e)(6)(D)(II). A referral will be made to Compliance and Practices for this violation. The requestor submitted relevant information to support delivery of service. Recommend reimbursement of \$300.00.

The total for the fee issues is \$315.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and Rule 134.202(c)(1).

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 carrier must refund the amount of the IRO fee (\$460.00) to the requestor. The Division has determined that the requestor is entitled to reimbursement in the amount of \$5,147.27. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20 days of receipt of this Order.

Findings and Decision and Order by:

Donna Auby

6-14-05

Margaret Ojeda

6-14-05

Authorized Signature

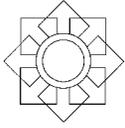
Typed Name

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.



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 6, 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 #: M5-05-2165-01
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 45 year-old male injured his back and right shoulder on ____ when the heavy door he was carrying over his head hit the door jam he was attempting to pass through and twisted his back. He has been treated with therapy, medications and epidural injections.

Requested Service(s)

Office visits (99204 and 99213), functional capacity evaluation, ultrasound, massage therapy, aquatic therapy for dates of service 09/13/04 through 01/27/05

Decision

It is determined that there is medical necessity for the office visits (99204 and 99213), functional capacity evaluation, ultrasound, massage therapy, and aquatic therapy for dates of service 09/13/04 through 01/27/05 to treat this patient's medical condition.

Rationale/Basis for Decision

Expectation of improvement in a patient's condition should be established based on success of treatment. Continued treatment is expected to improve the patient's condition and initiate restoration of function. If

treatment does produce the expected positive results, it is reasonable to continue that course of treatment.

Medical record documentation indicates objective and functional improvement in this patient's condition and the disputed services fulfilled statutory requirements¹ for requirements of medical necessity. The patient obtained relief, promotion of recovery was accomplished and there was an enhancement of the employee's ability to return to employment. Therefore, the office visits (99204 and 99213), functional capacity evaluation, ultrasound, massage therapy, and aquatic therapy for dates of service 09/13/04 through 01/27/05 are 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 #: M5-05-2165-01

Information Submitted by Requestor:

- Progress Notes
- Consults
- Impairment Rating
- Diagnostic Tests
- Denials/Claims

Information Submitted by Respondent:

- Claims