

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 (X) No
Requestor's Name and Address Network of Physicians Mgmt. Inc. 943 Exp. #15 PMB 9100 Brownsville, TX 78520	MDR Tracking No.: M5-05-2357-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address TX Mutual Insurance Company, Box 54	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		
5-4-04, 6-4-04, 7-8-04, 8-5-04, 9-7-04, 10-4-04		CPT code 99212	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
12-7-04	1-12-05	CPT codes 97035, 97124	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
5-4-04	10-21-04	99212 (except as noted above), 97110, G0283, 97035, 97124	<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 majority of disputed medical necessity issues. The total amount due the requestor for the medical necessity issues is \$502.04.

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 6-17-05 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 code 99080-73 on 6-14-04 and 8-9-04 was denied as "TD – the TWCC 73 was not properly completed or was submitted in excess of the filing requirements." The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). **Recommend reimbursement of \$30.00 (\$15.00 X 2 DOS).**

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 reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee. \$ The Division hereby **ORDERS** the insurance carrier to remit the appropriate amount for the services in dispute consistent with the applicable fee guidelines, totaling \$517.04, 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	8-1-05
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.



7600 Chevy Chase, Suite 400
Austin, Texas 78752
Phone: (512) 371-8100
Fax: (800) 580-3123

NOTICE OF INDEPENDENT REVIEW DECISION

Date: July 15, 2005

To The Attention Of: TWCC
7551 Metro Center Drive, Suite 100, MS-48
Austin, TX 78744-16091

RE: Injured Worker: _____
MDR Tracking #: M5-05-2357-01
IRO Certificate #: 5242

Forté 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 Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté has performed an independent review of the proposed 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 Chiropractic reviewer who has an ADL certification. The reviewer 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 for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- Table of disputed services
- Medical dispute letter
- HCFA 1500s
- Exercise sheets
- Daily notes
- EOBs
- Discogram report
- Surgical notes

Submitted by Respondent:

- None were submitted

Clinical History

The documentation supplied for review begins in May 2004, which is approximately ___ months after the injury occurred. The date of injury reported on the HCFA 1500s was ____. The injury occurred to the lumbar and testicular region. There is no initial examination form submitted for review. There is no documentation from the date of injury through May 2004. On a daily note dated 6/1/04 it was reported that the first exam on the claimant was completed on 11/5/03. That daily note also reported that the claimant had lumbar and testicular pain, and was undergoing electrical stimulation and therapeutic exercises. The assessment reports that the claimant was awaiting lumbar surgery. A discogram on 6/28/04 revealed an anterior herniation at L3/4 with fairly prominent concordant back pain. There is an anterior herniation with a diffuse mild bulge noted with absence of pain during the intradiscal injection. There was a posterior herniation at L5/S1 with no concordant back pain experienced. Active and passive therapy continued with the chiropractor. On 10/21/04 the claimant underwent lumbar surgery at multiple levels from L3 to S1 which included a posterior interbody fusion at L3/4 and discectomy on the right. The claimant returned to therapy which went through 1/12/05. The documentation ends here.

Requested Service(s)

99212 office visit, 97110 therapeutic exercises, G0283 electrical stimulation, 97035 ultrasound, 97124 massage therapy for dates of service 5/4/04 through 1/12/05

Decision

I agree with the carrier that the services from 5/4/04 through 10/21/04 were not medically necessary with the exception of monthly office visits dated 5/4/04, 6/4/04, 7/8/04, 8/5/04, 9/7/04 and 10/4/04 (CPT code 99212). I disagree with the carrier and find that the dates of service from 12/7/04 through 1/12/05 were medically necessary.

Rationale/Basis for Decision

The supplied documentation does not begin until May 2004. The daily notes report that the claimant had a first exam in November 2003, shortly after the date of injury. Without any objective documentation supplied, I am left to assume that the claimant underwent an adequate amount of passive and active therapies in the initial 7 months post injury. The daily note dated 6/1/04 reported the claimant was already awaiting lumbar surgery. At that time it had been determined that conservative care had failed and invasive procedures were medically necessary. Continuing ongoing passive and active modalities while waiting for surgery are not seen as medically necessary nor supported by the objective documentation supplied. It would be necessary to continue monthly office visits to document the claimant's symptoms and refer to

other physicians as needed. Once the claimant's surgery was completed on 10/21/04, several months of post surgical care would be deemed reasonable and medically necessary. The active and passive therapies rendered after the surgery through 1/12/05 are considered reasonable and medically necessary.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 15th day of July 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder