

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 Horizon Health % Bose Consulting, L. L. C. P. O. Box 550496 Houston, Texas 77255	MDR Tracking No.: M5-05-2474-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Alief ISD % Health Admin Services, Box 42	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		
7-15-04	9-3-04	CPT codes 97140, 97110, 99212, 97112, 99071, 97535	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
7-15-04	9-3-04	CPT codes G0283 and 97032	<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 **prevailed** on the majority of the disputed medical necessity issues. The total amount due the requestor for the medical necessity services is \$4,975.10.

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 6-24-05 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 and HCPCS Code E0238 on 7-15-04: the carrier provided a check number to confirm that these services were reimbursed to the requestor. No additional reimbursement recommended.

CPT code 99070 on 7-15-04 was denied by the carrier as "N – not appropriately documented." Texas Labor Code 413.011 (d) and Rule 133.304 (i) (1-4) place certain requirements on the Requestor when billing for services for which the Commission has not established a maximum allowable reimbursement. Per Rule 133.307(g)(3)(D), the Requestor is required to discuss, demonstrate and justify that the payment being sought is a fair and reasonable rate of reimbursement. The Requestor has not provided sample EOBs or other evidence that the fees billed are for similar treatment of injured individuals and that reflect the fee charged to and paid by other carriers. Recommend no reimbursement.

CPT code 99204 on 7-16-04 was denied by the carrier as "N – not appropriately documented." The 2002 MFG identifies this criteria for this CPT code: "Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family." The Initial Report provided by the requestor for this date of service supports these criteria. Recommend reimbursement of \$173.55.

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 \$5,148.65, 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:

_____	_____	8-17-05
Ordered by:	_____	_____
_____	Margaret Ojeda	8-17-05
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

If you are unhappy with all or part of this decision, you have the right to appeal the decision. Those who wish to appeal decisions that were issued during the month of August 2005, should be aware of changes to the appeals process which take effect September 1, 2005.

House Bill 7, recently enacted by the 79th Texas Legislature, provides that an appeal of a medical dispute resolution order that is not pending for a hearing at the State Office of Administrative Hearings (SOAH) on or before August 31, 2005 is not entitled to a SOAH hearing. This means that the usual 20-day window to appeal to SOAH, found in Commission Rule 148.3, will be shortened for some parties during this transition phase. If you wish to seek an appeal of this medical dispute resolution order to SOAH, you are encouraged to have your request for a hearing to the Commission as early as possible to allow sufficient time for the Commission to submit your request to SOAH for docketing. A request for a SOAH 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.

Beginning September 1, 2005, appeals of medical dispute resolution 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.

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

NOTICE OF INDEPENDENT REVIEW DECISION

August 5, 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 # : M5-05-2474-01
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 care. 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 41 year-old female injured her lower back and right knee on ___ while performing her normal work activities. She has been treated with therapy.

Requested Service(s)

Electrical stimulation (unattended), manual therapy technique, therapeutic exercise, office visit, neuromuscular reeducation, educational supplies, electrical stimulation (manual), self-care/home management training for dates of service 07/15/04 through 09/03/04

Decision

It is determined there is no medical necessity for the electrical stimulation (unattended) and electrical stimulation (manual) to treat this patient's medical condition for dates of service 07/15/04 through 09/03/04. However, there was medical necessity for the manual therapy technique, therapeutic exercise, office visit, neuromuscular reeducation, educational supplies, and self-care/home management training for dates of service 07/15/04 through 09/03/04 to treat this patient's medical condition.

Rationale/Basis for Decision

Medical record documentation indicates this patient was injured while descending a school bus lift chair and missed the final step. She fell forward and injured her right knee and lower back. National treatment guidelines allow for active therapy for this type of injury. She had received same therapy prior to the dates in question but continued to have ongoing problems necessitating additional treatment. There is sufficient documentation and objective clinical findings to warrant the manual therapy technique, therapeutic exercise, office visit, neuromuscular reeducation, educational supplies, and self-care/home management training. Therefore, the manual therapy technique, therapeutic exercise, office visit, neuromuscular reeducation, educational supplies, and self-care/home management training for dates of service 07/15/04 through 09/03/04 were medically necessary to treat this patient's medical condition.

There are no treatment guidelines for passive therapy activities for this type of injury. In this case, passive therapy activities include electrical stimulation. Therefore, electrical stimulation (unattended) and electrical stimulation (manual) for dates of service 07/15/04 through 09/03/04 were not medically necessary to treat this patient's medical condition.

Sincerely,

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

GBS:vn