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
Requestors Name and Address Richard Stephenson, D. C. 322 North Main St. Bryan, TX 77803	MDR Tracking No.: M5-05-2526-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address **Liberty Mutual Fire Insurance, Box 28**	Date of Injury: Employer's Name: Insurance Carrier's No.:

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

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	**To**		
11-3-04	**1-7-05**	**CPT codes 99213, 97530, 97032, 97035, 97024**	☒ **Yes** ☐ **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 amount due the requestor for the medical necessity issues is $387.94.

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 6-27-05 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 97750 on 11-5-04: Neither the carrier nor the requestor provided EOB's. The requestor 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 per the 2002 MFG of $34.30.

Regarding CPT code 99213 on 11-8-04 and 11-10-04: Neither the carrier nor the requestor provided EOB's. The requestor 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 $100.00 ($50.00 (Requestor's charge) X 2 DOS.

Regarding CPT code 97530 on 11-8-04 and 11-10-04: Neither the carrier nor the requestor provided EOB's. The requestor 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 $138.60 ($69.30 X 2 DOS).

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 $660.84, 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.

Ordered by:

		8-24-05
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 in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

August 23, 2005

TEXAS WORKERS COMP. COMISSION
AUSTIN, TX 78744-1609

CLAIMANT: ___
EMPLOYEE: ___
POLICY: M5-05-2526-01
CLIENT TRACKING NUMBER: M5-05-2526-01/5278

Medical Review Institute of America (MRIoA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Workers Compensation Commission has assigned the above mentioned case to MRIoA for independent review in accordance with TWCC Rule 133 which provides for medical dispute resolution by an IRO.

MRIoA has performed an independent review of the case in question to determine if the adverse determination was appropriate. In performing this review all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the TWCC approved doctor list (ADL). The reviewer has signed a statement indicating they have no known conflicts of interest existing between themselves and the treating doctors/providers for the patient in question or any of the doctors/providers who reviewed the case prior to the referral to MRIoA for independent review.

Records Received:
RECORDS RECEIVED FROM THE STATE:
Notification of IRO Assignment dated 6/28/05, 11 pages

RECORDS RECEIVED FROM DR. STEVE OPERSTENY:
Physical Medicine consultation follow up exam dated 12/7/04, 1 page
Physical Medicine consultation dated 11/2/04, 1 page

RECORDS RECEIVED FROM LIBERTY MUTUAL FIRE INSURANCE (RESPONDENT):
Notification letter of IRO assignment dated 6/27/05, 1 page
Preliminary Chiropractic Modality Review dated 11/17/04, 3 pages
Chart of visits, undated, 1 page
Dispute position statement dated 5/10/05, 2 pages
Office notes, 11/1/04 – 1/7/05, 5 pages
Functional Capacity Test, dated 11/5/04, 7 pages
Medical Dispute Resolution Request/Response, dated 5/20/05, 1 page

Summary of Treatment/Case History:
Patient was employed by , and was injured while pushing approximately 350 pounds of chickens. He stated injury to the abdominal area and was treated by Dr. Richard Stephenson and also managed by Dr. Opersteny (MD). The patient received treatment to the abdominal area that consisted of #97530, #97032, #97035, #97024 and #99213 exam and case evaluation management.

Questions for Review:
Dates of service in dispute: 11/3/04 - 1/7/05

1. Items in dispute: #99213 - OV, #97530- Therapeutic Activities, #97032 - Electrical Stimulation, #97035 - Ultrasound, #97024 - Diathermy. Denied for medical necessity. Please review for medical necessity.

Explanation of Findings:
1. Items in dispute: #99213 - OV, #97530- Therapeutic Activities, #97032 - Electrical Stimulation, #97035 - Ultrasound, #97024 - Diathermy. Denied for medical necessity. Please review for medical necessity.

Injury to the soft tissue, in this case the abdominal musculature is treated by the application of ultrasound #97035 and interferential #97032, diathermy #97024, and soft tissue manipulation such as massage or vibratory massage in this case. CPT #99213 is the code for evaluation and management of the patients case. It is not uncommon to see pain for this length of time when the patient is deconditioned. In clinical experience patients may present in pain for extended lengths of time and require more care when deconditioned or when other co contributing factors to healing exist. Review of the subjective complaints of the patient and the objective findings of the doctor, this is likely for this case.

Conclusion/Decision to Certify:
Decision to certify care for this time frame of 11-3-04 thru 1-7-05 for the codes of #97032, #97035, #97024, #97530 and #99213.

References Used in Support of Decision:
Soft Tissue and Rheumatic pain -Sheon
Clinical Orthopaedic Rehab - Wilk

The physician providing this review is board certified in chiropractic medicine. The reviewer also holds additional certifications in Acupuncture and Orthopedics. The reviewer is a member of their state chiropractic association and is certified to provide reviews for the workers compensation commission as a designated doctor, RME and IME. The reviewer has been in active practice since 1998.
MRIoA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the treating provider, payor and/or URA, patient and the TWCC.

It is the policy of Medical Review Institute of America to keep the names of its reviewing physicians confidential. Accordingly, the identity of the reviewing physician will only be released as required by state or federal regulations. If release of the review to a third party, including an insured and/or provider, is necessary, all applicable state and federal regulations must be followed.

Medical Review Institute of America retains qualified independent physician reviewers and clinical advisors who perform peer case reviews as requested by MRIoA clients. These physician reviewers and clinical advisors are independent contractors who are credentialed in accordance with their particular specialties, the standards of the American Accreditation Health Care Commission (URAC), and/or other state and federal regulatory requirements.

The written opinions provided by MRIoA represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to MRIoA for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Medical Review Institute of America assumes no liability for the opinions of its contracted physicians and/or clinician advisors. The health plan, organization or other party authorizing this case review agrees to hold MRIoA harmless for any and all claims which may arise as a result of this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

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