



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:	MDR Tracking No.: M5-05-2809-01
South Coast Spine and Rehab, P. A. 620 Paredes Line Road Brownsville, TX 78521	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:
American Home Assurance Company, Box 19	

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included TWCC 60 form, Explanations of Benefits, medical documentation and CMS 1500's. Position summary states, "We are requesting that the MRD adjudicate the payment using the appropriate medical dispute resolution actions. We have provided the medical review dispute resolution officer a systematic way to verify that we have complied with Rule 133.307."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The carrier provided a TWCC 60. The position summary states, "The carrier has denied reimbursement for the disputed services because the treatment was not medically reasonable and necessary. The underlying treatment includes office visits and physical medicine modalities. There is no evidence of the efficacy of this treatment."

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
2-22-05 – 3-21-05	CPT codes 97110, 99213, 97035, 97113	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	-0-

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 **not** prevail on the disputed medical necessity issues.

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 7-22-05 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.

The carrier denied CPT Code 99080-73 on 2-22-05 with a "V" for unnecessary medical treatment based on a peer review; however, the TWCC-73 is a required report per Rule 129.5 and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. Recommend reimbursement of \$15.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 129.5.

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 Division has determined that the requestor is not entitled to a refund of the paid IRO fee. The Division hereby **ORDERS** the insurance carrier to remit additional reimbursement totaling \$15.00 plus all accrued interest due at the time of payment to the Requestor within 30-days of receipt of this Order.

Findings and Decision and Order by:

Authorized Signature

Typed Name

9-22-05

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.



Barton Oaks Plaza Two, Suite 200
901 Mopac Expressway South - Austin, TX 78746-5799
Phone: 512-329-6610 - Fax: 512-327-7159 - www.tmf.org

NOTICE OF INDEPENDENT REVIEW DECISION

August 26, 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 #: M5-05-2809-01
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 56 year-old female injured her left knee on ___ when she bent down and stood up and felt a pop in her knee. A meniscal tear was confirmed on MRI and arthroscopy in _____. She underwent a medical meniscectomy.

Requested Service(s)

Therapeutic exercises, office visits, ultrasound, and aquatic therapy with dates of service from 02/22/05 to 03/21/05.

Decision

It is determined that the therapeutic exercises, office visits, ultrasound, and aquatic therapy with dates of service from 02/22/05 to 03/21/05 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

Surgery was performed on this patient on 04/14/2004 and she underwent post-operative rehabilitation. The third functional capacity evaluation found that she was released to return to work and to follow up treatment on as needed bases. Over the course of treatment this patient received rehabilitation and recovered from her injury and released from treatment.

Sincerely,



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

GBS:vn

Attachment

Attachment

Information Used by TMF in Decision

Patient Name: _____

TWCC ID #: M5-05-2809-01

Medical record documentation provided:

- Office Visit Notes
- Diagnostic Tests
- Procedures
- Medical Record Review
- Psychological Evaluation
- Notes from 2001
- Hospital Records
- Requests for Reconsideration
- Claims