



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: Behavioral Healthcare Associates 4101 Greenbriar, Suite 115 Houston, Texas 77098	MDR Tracking No.: M5-05-3000-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Federal Ins Company, Box 17	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The services denied for "U" were medically necessary. The services denied for "N" were documented. Preauthorization was obtained for CPT codes 96151 and 96152.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No position summary was received.

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)
7-15-04	CPT codes 90801 and 90889	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$289.00

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 \$289.00.

Based on review of the disputed issues within the request, the 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 8-10-05 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 96152 on 8-3-04 and 8-10-04 was denied by the carrier as "N – not appropriately documented." The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Reimbursement of \$248.48 (\$31.06 X 8 units) is recommended.

CPT code 96151 on 8-3-04 and 8-10-04 was denied by the carrier as "N – not appropriately documented." The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Reimbursement of \$65.00 (\$32.50 X 2 units) is recommended.

Regarding CPT code 96151 on 9-3-04: 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 \$65.00 (\$32.50 X 2 units).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308

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 parties are instructed to review the IRO decision and take appropriate action. For any services that may have been found to be medically necessary, the insurance carrier is instructed to process those services through their bill review and payment processes, including issuing any additional amounts due consistent with the established fee guidelines. The carrier must refund the amount of the IRO fee within to the requestor within 30-days of receipt of this order. 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 entitled to additional reimbursement in the amount of \$667.48. 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 30-days of receipt of this Order.

Findings and Decision and Order by:

Donna Auby

9-15-04

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.



Specialty Independent Review Organization, Inc.

08/29/2005

TWCC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient:
TWCC #:
MDR Tracking #: M5-05-3000-01
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to Specialty IRO for independent review in accordance with TWCC Rule 133.308, which allows for medical dispute resolution by an IRO.

Specialty IRO has performed an independent review of the care rendered 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.

This case was reviewed by a licensed Ph.D. and Licensed Professional Counselor with a specialty in Counseling. The reviewer is on the TWCC ADL. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

The patient, a 26-year-old female, was injured on the job while moving a heavy table across the floor on _____. She has had X-rays and two MRIs that concluded she had a 2mm protrusion at 4-5 level and a 3mm protrusion at L5-S1. She has received passive modality treatments, two sets of epidural injections and facet injections. The patient has made several visits to the emergency room due to severe pain.

RECORDS REVIEWED

Explanation of Review by Federal Insurance Group 09/18/2004
Report by S. Callahan 8/16/05
Psychological Clinical Interview by G. Valenzuela & P. McBride-Houtz - 7/15/04
Treatment Summary and Extension Request by M. Snyder
Required Medical Examination by D. Leong - 6/11/04
RME Addendum by D. Leong - 6/30/04
Peer Review by T. Troutt - 10/12/04

DISPUTED SERVICES

Disputed services include a psychiatric diagnostic interview examination 90801, preparation of the report of the patient's psychiatric status, history, treatment or progress for other physicians/agencies/insurance carrier - 90889.

DECISION

The reviewer disagrees with the previous adverse determination.

BASIS FOR THE DECISION

In order to determine the need for treatment and plan treatment if necessary, an evaluation is appropriate and equitable. AMA guidelines for the treatment of pain, CARF guidelines for multidisciplinary treatment, Medicare guidelines for the use of psychological evaluations, and TWCC treatment guidelines have all acknowledged the importance of such evaluations in the diagnosis and treatment planning processes critical to quality patient care.

Because services such as psychotropic medications, counseling services, and participation in a multidisciplinary chronic pain management program were delivered to this patient as a result of this evaluation and report, this disputed service is medically reasonable and necessary.

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that there is no known conflict between the reviewer, Specialty IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,

Wendy Perelli, CEO

CC: Specialty IRO Medical Director