



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.: M5-05-3110-01
Dr. Harold B. Tondera, D. C. Inc. 9119 S. Gessner, Suite 201 Houston, Texas 77074	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:
Zurich American Insurance Company, Box 19	

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included TWCC 60 form, Explanations of Benefits and CMS 1500's. Position summary states, "I have copies of the original bills which clearly marked the request for reconsideration, along with the carrier's original EOB and a letter dated 7-17-05 explaining the provider's position."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The carrier submitted the TWCC 60. The position summary stated, "The request for resubmission was not complete and fails to satisfy the prerequisite for medical dispute resolution. This matter is not ripe for review and should be dismissed pursuant to 28 TAC 133.307."

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)
3-7-05 – 4-8-05	CPT codes 99212 and 97530-59	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$3,000.00

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 \$3,000.00.

Per Rule 134.202(d), reimbursement shall be the least of the (1) MAR amount as established by this rule or, (2) the health care provider's usual and customary charge).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 134.202(d).

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. The carrier must refund the amount of the IRO fee, which is \$460.00, 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 reimbursement in the amount of \$3,000.00. 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:

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.

September 7, 2005

TEXAS WORKERS COMP. COMMISSION
AUSTIN, TX 78744-1609

CLAIMANT: ___
EMPLOYEE: ___
POLICY: M5-05-3110-01
CLIENT TRACKING NUMBER: M5-05-3110-01/5278

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 8/23/05, 9 pages

RECORDS RECEIVED FROM DR. TONDERA:

Employee notice of injury or occupational disease claim for compensation dated 1 page
Office policy, workers comp claims, dated 7/26/05, 1 page
TWCC Work Status Report dated 7/21/04, 9/7/04, 10/26/04, 11/16/04, 12/7/04, 1/4/05, 4/12/05, 7 pages
Medical records from Dr. Tondera, with x-ray report dated 7/21/04, 4 pages
Diagnostic Radiology report dated 8/16/04, 8/19/04, 8/24/04, 5 pages
Letter from Tondera Chiropractic to Eric Berkman, MD dated 8/31/04, 3 pages
Letter dated 9/7/04 from Eric Berkman MD to Eric Tondera DC, 1 page
Office notes of Dr. Berkman dated 9/7/04, 10/26/04, 4 pages
Dr. Prescription dated 10/26/04, 2 pages
PT note dated 11/16/04, 2 pages
Physician referral dated 11/17/04, 1 page
Dr. Prescription undated, 1 page
Letter dated 11/17/04 from Tondera Chiropractic, 4 pages
Report of FCE dated 11/24/04, 16 pages
Letter dated 12/2/04 from Eric Tondera DC, 1 page
Office visit 12/7/04, 1/4/05, 4/12/05 6 pages
Letter dated 12/20/04 from Eric Tondera DC, 1 page
Letter dated 1/3/05 from Eric Tondera DC, 1 page
Peer review summary dated 12/18/04, 3 pages
Progress Notes from Dr. Tondera, 7/21/04-5/3/05, 5 pages
Handwritten progress notes, 7/21/04-5/3/05, 16 pages
TWCC Report of medical Evaluation dated 4/14/05, 6/27/05, 6 pages
Summary of studies, 6 pages
Letter dated 6/17/05, 3 pages
HCFA billings 8 pages, 3/7/05-4/8/05
EOBs, 4 pages
Letter dated 6/27/05, 2 pages
Review of medical history & physical exam dated 6/27/05, 6 pages
EOB 3/7/05-4/8/05, 1 page
Duplicate HCFA billings, 4 pages
Peer review report dated 12/18/04, 3 pages
TWCC Medical Dispute Resolution Request/Response 6 pages
Duplicate records, 20 pages

Summary of Treatment/Case History:

The patient underwent physical medicine treatments after injuring his right shoulder on ___ when tripped on stairs and fell into a railing.

Questions for Review:

DOS in dispute 3/7/05-4/8/05:

1. Please address medical necessity of items in dispute: CPT code #99212-OFFICE VISITS, #97530-59-THERAPEUTIC ACTIVITIES.

Explanation of Findings:

1. Please address medical necessity of items in dispute: CPT code #99212-OFFICE VISITS, #97530-59-THERAPEUTIC ACTIVITIES.

CPT #99212 and #97530 were medically necessary from 3/7/05-4/8/05.

Expectation of improvement in a patient's condition should be established based on success of treatment. Continued treatment is expected to improve the patient's condition and initiate restoration of function. If treatment does not produce the expected positive results, it is not reasonable to continue that course of treatment. With documentation of improvement in the patient's condition and restoration of function, continued treatment may be reasonable and necessary to effect additional gains.

There is adequate documentation of objective and functional improvement in the patient's condition.

Therefore, and without question, the medical records fully substantiate that the disputed services fulfilled statutory requirements for medical necessity since the patient obtained relief, promotion of recovery was accomplished and there was an enhancement of the employee's ability to return to or retain employment.

Conclusion/Decision to Certify:

CPT #99212 and #97530 were medically necessary from 3/7/05-4/8/05.

References Used in Support of Decision:

Texas Labor Code 408.021

This review was provided by a chiropractor who is licensed in Texas, certified by the National Board of Chiropractic Examiners, is a member of the American Chiropractic Association and has several years of licensing board experience. This reviewer has written numerous publications and given several presentations with their field of specialty. This reviewer has been in continuous active practice for over twenty-five years.

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.