



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.: M5-06-0058-01
Syzygy Associates, L.P. P. O. Box 25006 Fort Worth, TX 76124	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:
Texas Mutual Insurance Company, Box 54	

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 form, Explanations of Benefits, Medical Documentation and CMS 1500's. Position summary states, "All time is documented in the notes. The treatment and lengthy amount of time was found to be medically necessary."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 form and Explanations of Benefits. Position summary states, "The requestor believes it is entitled to an additional \$3,020.96."

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)
12-6-04 – 2-14-05	CPT codes 97032, 97530, 97110, 97112	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2,073.66

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 \$2,073.66.

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 9-26-05 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 97152 on 12-7-04, and 96152 on 1-3-05: Per Rule 133.307 (e)(2)(A) there was no copy of the medical bill as originally submitted to the carrier for reconsideration in accordance with 133.304. Recommend no reimbursement.

Regarding CPT code 96152 on 12-27-04, 1-17-05, 1-19-05, 1-27-05 and 2-2-05: The carrier has denied these services as "435 - The value of this procedure is included in the value of the comprehensive procedure." Per the 2002 MFG CPT code 96152 is considered by Medicare to be a component procedure of CPT code 90806 which was billed on these dates. The services represented by the code combination will not be paid separately.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and Rule 134.202(c)(1).

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 carrier must refund the amount of the IRO fee (\$460.00) to the requestor within 30 days of receipt of this order. The Division has determined that the requestor is entitled to reimbursement in the amount of \$2,073.66. 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

12-01-05

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.

NOTICE OF INDEPENDENT REVIEW DECISION

November 8, 2005

Program Administrator
Medical Review Division
Division of Workers Compensation
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Claim #: _____
Injured Worker: _____
MDR Tracking #: M5-06-0058-01
IRO Certificate #: IRO4326

TMF Health Quality Institute (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review

organization (IRO). The Division of Workers' Compensation (DWC) 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 Medicine. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and the provider, the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient sustained a work-related injury on ___ which resulted in pain to her lower back. The patient was seen for an evaluation and a treatment program was begun. An MRI was ordered and a disc problem was confirmed. Progression into an aggressive active therapy program was indicated.

Requested Service(s)

Electrical stimulation, therapeutic activities, therapeutic exercises, and neuromuscular reeducation provided from 12/06/2004 through 02/14/2005.

Decision

It is determined that the electrical stimulation, therapeutic activities, therapeutic exercises, and neuromuscular reeducation provided from 12/06/2004 through 02/14/2005 were medically necessary to treat this patient's condition.

Rationale/Basis for Decision

There is sufficient medical record documentation to justify the treatment that was rendered. Some guidelines limit the total time of treatment per visit to 30 to 45 minutes. In some cases this limitation is acceptable. However, this case does not fit these guidelines. The clinical documentation substantiates this patient's need for the specific treatment and the time needed on each visit to accomplish the prescribed program. On 01/24/2005 during the treatment in question, the patient was seen for a designated doctor examination. At that time, the designated doctor determined the patient was not at maximum medical improvement and elected to allow her to finish the therapy program.

Sincerely,

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

GBS:dm