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: North Texas Pain Recovery Center 6702 West Poly Webb Road Arlington, Texas 76016	MDR Tracking No.: M5-06-0180-01 Claim 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: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 form. Position summary states, "Medically necessary per treating physician."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response.

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)
2-23-05 – 3-24-05	CPT code 97001	☒ Yes ☐ No	$94.35
2-23-05 – 3-24-05	CPT code 97750 (8 units)	☒ Yes ☐ No	0
2-23-05 – 3-24-05	CPT code 97545 -WH-CA ($64.00 x 24 hours)	☒ Yes ☐ No	$1,536.00
2-23-05 – 3-24-05	CPT code 97546-WH-CA ($64.00 x 56 hours)	☒ Yes ☐ No	$3,584.00
GRAND TOTAL			$5,214.35

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 $5,214.35.

CPT codes 97001 and 97750 were both found to be medically necessary by the IRO. However, CPT code 97750 is considered by Medicare to be a component procedure of CPT code 97001. There are no circumstances in which a modifier would be appropriate. The services represented by the code combination will not be paid separately.

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 12-20-05 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 99199 on 5-6-05 was denied by the carrier as "X322-Documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge." The requestor provided no documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Apparently this CPT code was used for Travel Expenses. Per Rule 134.6 travel expenses are not handled in MDR, but in the local office. No reimbursement recommended.

CPT code 97545-WHCA and CPT code 97546-WHCA on 3-3-05 and 3-4-05 were denied by the carrier as "X170-Pre-Authorization was required, but not requested for this service." Per Advisory 2001-14, preauthorization for work hardening or work conditioning programs is not required for CARF accredited providers. Reimbursement is at the CARF rate according to 134.202 (e)(5)(C)(ii) at $64 per hour. Recommend reimbursement of $640.00 ($64.00 x 10 hours).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.307, 133.308 and Rule 134.202.

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 ($650.00) 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 $5,854.35. 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 by:

		1-12-06
Order by:		
	Margaret Ojeda	1-12-06
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.

NOTICE OF INDEPENDENT REVIEW DECISION

December 7, 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:	___
	Tracking #:	M5-06-0180-01
	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 DWC §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 TMF physician reviewer who is board certified in Family Practice which is the same specialty as the treating physician, provides health care to injured workers, and licensed by the Texas State Board of Medical Examiners in 1977. 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 ___ when she complained of neck pain radiating into the left shoulder after lifting several boxes. An MRI of the neck revealed spondylosis at C5-C6 and C6-C7. The patient was treated with physical therapy, biofeedback, and epidural steroid injections.

Requested Service(s)

Physical therapy evaluation, physical performance testing, work hardening, and work hardening each additional hour provided from 02/23/2005 through 03/24/2005.

Decision

It is determined that the physical therapy evaluation, physical performance testing, work hardening, and work hardening each additional hour provided from 02/23/2005 through 03/24/2005 were medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The medical record documentation indicates that the patient responded positively to the treatment provided. As a result of the modalities provided from 02/23/2005 and 03/24/2005, the patient had decreased pain and was ultimately able to return to work.

This decision by the IRO is deemed to be a DWC decision and order.

YOUR RIGHT TO APPEAL

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other that a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code 413.031). 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. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for hearing and a **copy of this decision** must be sent to: Chief Clerk of Proceedings/Appeals Clerk, Texas Department of Insurance, Division of Workers' Compensation, P/O. Box 17787, Austin, Texas, 78744, Fax: 512-804-4011.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in this dispute.

Sincerely,

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

GBS:dm