



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.: M5-06-0868-01
Texas Health 5445 La Sierra Dr. #204 Dallas, Texas 75231	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:
Dallas ISD, Box 42	

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 package. Position summary states, "The insurance carrier is a habitual violator of TDI Rules and Regulations. They continually pay this procedure at a rate far below the guideline."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No response 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)
2-21-05	CPT code 90801	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$196.40

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 \$196.40.

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 1-31-06 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 90806 on 3-15-05, 3-25-05, 4-5-05, 4-12-05, 4-19-05, 6-28-05, 7-5-05, 7-12-05, and 7-20-05 was denied by the carrier as “12A – psychiatric reduction”, “50-These are non-covered services because this is not deemed a ‘medial necessity’ by the payer”, “15-Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider”, or “D19-Claim lacks Physician/Operative or other supporting documentation.” Partial payments had been made by the carrier. Per the 2002 MFG, CPT code 90806 is considered to be a component procedure of CPT code 90880. There are no circumstances in which a modifier would be appropriate. The services represented by the code combination will not be paid separately. Recommend no additional reimbursement.

CPT code 90880 on 7-5-05 was denied by the carrier as 15-Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider”. Per Rule 134.600 this service does not require preauthorization. Recommend reimbursement of \$160.16.

CPT code 90880 on 7-12-05 was denied by the carrier as “D19-Claim lacks Physician/Operative or other supporting documentation”. The requestor did not provide documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Reimbursement is not recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.307, 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 \$356.56. 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

Donna Auby

Typed Name

2-28-06

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

February 20, 2006

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 #: M5-06-0868-01
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 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 ___ when she backed into a carpet cleaner and fell, causing injury to her right shoulder, right knee, right hip, right wrist and right ankle. Treatment has included intense evaluation and treatment program to include surgical intervention.

Requested Service(s)

90801 – Psychiatric diagnostic interview

Decision

It is determined that the 90801 – psychiatric diagnostic interview was medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The patient continued to experience ongoing problems for which her treating doctor referred her for an initial behavioral medicine consultation. The consultation was to evaluate her emotional status and subjective pain, coping and adjustment to determine relationship to the work accident and assess her injury related disturbances in mood. She had received treatment but continued to verbalize distress regarding a number of physiological changes stemming from her injury to include change in appetite, feeling nauseous, breaking into sweats or becoming easily chilled, muscle spasm/tension, tightness in her jaw, frequent headaches, feeling tired and weak all over, waking up often during the night, suffering from

constant

pain, and requiring medications to relieve her pain and guarding/bracing. She had reported her pain scale to be a 6/10. Her pain level interfered with her recreational, social, normal and familial activities. She also remained off work secondary to her injury and pain.

National treatment guidelines allow for an initial behavioral consultation in situations like this. Therefore, it is determined that the requested services were medically necessary to treat the patient's on the job injury.

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 than 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.

Sincerely,

A handwritten signature in black ink that reads "Gordon B. Strom, Jr." in a cursive style.

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

GBS:dm

Attachment

Information Submitted to TMF for Review

Patient Name:

Tracking #: M5-06-0868-01

Information Submitted by Requestor:

- Table of disputed services
- Initial Behavioral Medicine Consultation
- Initial Behavioral Medicine Consultation (Addendum)
- Individual Psychotherapy Notes

Information Submitted by Respondent:

None