



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: Pedro Nosnik MD PA 4100 W 15th Street Suite 206 Plano TX 75093	MDR Tracking No.: M5-06-0975-01
Respondent's Name and Address: Texas Mutual Insurance Box 54	Claim No.:
	Injured Worker's Name:
	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DWC-60 package. Position Summary: This is for intraoperative monitoring. The surgeon needed this procedure done.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Response to DWC-60 package. Position Summary: On the original bill the requestor billed code 99070 for the EMG supplies. On the request for reconsideration, the requestor changed the code from 99070 to various "A" codes and labeled the reconsideration as "Rebill Corrected Claim."

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Amount Due (if any)
6-9-05	95925-76-22 \$75.94 x 2 =	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$152.88
	95926-76-22 \$76.35 x 2 =	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$152.70
	Total		\$305.58

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 **prevailed** on the disputed medical necessity issues.

Based on review of the disputed issues within the request, Medical Review 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 3-2-06, Medical Review submitted a Notice to the 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.

The carrier states that the requestor did not properly submit for reconsideration the supply code (99070, A4215). The original CMS-1500 submitted by the carrier shows code 99070 and the request for reconsideration submitted by the requestor shows A4215 (marked REQUEST FOR RECONSIDERATION and REBILL CORRECTED CLAIM). Per Rule 133.304 (k) the requestor may request reconsideration by submitting a copy of the complete medical bill clearly marked with the statement "REQUEST FOR RECONSIDERATION" with the identical codes and charges that are on the original medical bill along with a copy of the EOB and a claim-specific substantive explanation. The requestor did not make a proper request for reconsideration; therefore, no review and no reimbursement recommended for the supply code.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.202

PART VII: DIVISION DECISION AND 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 \$305.58. In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of \$650.00. 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.

Ordered by:

Medical Dispute Officer

5-11-06

Authorized Signature

Typed Name

Date

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.



PROFESSIONAL ASSOCIATES

NOTICE OF INDEPENDENT REVIEW

NAME OF PATIENT:
IRO CASE NUMBER: M5-06-0975-01
NAME OF REQUESTOR: Pedro Nosnik, M.D.
NAME OF PROVIDER: Jack Zigler, M.D.
REVIEWED BY: Board Certified in Neurology
IRO CERTIFICATION NO: IRO 5288
DATE OF REPORT: 04/12/06

Dear Dr. Nosnik:

Professional Associates has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO) (#IRO5288). Texas Insurance Code Article 21.58C, effective September 1, 1997, allows a patient, in the event of a life-threatening condition or after having completed the utilization review agent's internal process, to appeal an adverse determination by requesting an independent review by an IRO.

In accordance with the requirement for TDI-Division of Workers' Compensation (DWC) to randomly assign cases to IROs, DWC has assigned your case to Professional Associates for an independent review. The reviewing physician selected has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, the reviewing physician reviewed 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.

This case was reviewed by a physician reviewer who is Board Certified in the area of Neurology and is currently listed on the DWC Approved Doctor List.

I am the Secretary and General Counsel of Professional Associates and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him 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 Independent Review Organization.

REVIEWER REPORT

Information Provided for Review:

An evaluation with an unknown provider (no name or signature was available) dated 09/23/04
An MRI of the cervical spine interpreted by Richard Randall Ozmun, M.D. dated 11/26/04
A cervical myelogram CT scan interpreted by Dr. Marlon Hughes (no credentials were listed) dated 03/15/05
An evaluation with Jack E. Zigler, M.D. dated 03/23/05
An operative report from Dr. Zigler dated 06/09/05
Intraoperative neurophysiological monitoring with Pedro Nosnik, M.D. dated 06/09/05
A letter of dispute from LaTreace E. Giles, R.N. at Texas Mutual Insurance Company dated 03/22/06

Clinical History Summarized:

The unknown physician recommended an MRI, EMG/NCV studies, and Lodine on 09/23/04. An MRI of the cervical spine interpreted by Dr. Ozmun on 11/26/04 revealed narrowing of the spinal canal secondary to a disc bulge most significant at C4-C5 and C3-C4. A cervical myelogram CT scan interpreted by Dr. Hughes on 03/15/05 revealed ventral extradural indentation to the thecal sac at C4-C5 and smaller at C3-C4, along with a herniation at C4-C5 that severely compromised the canal and cord and a smaller herniation at C3-C4. Dr. Zigler recommended a neurological evaluation and surgery on 03/23/05. On 06/09/05, Dr. Zigler performed an anterior discectomy and fusion, maximal discectomy, partial corpectomy, fusion, and internal fixation at C3-C4 and C4-C5. Intraoperative monitoring with Dr. Nosnik on 06/09/05 was performed. On 03/22/06, Ms. Giles from Texas Mutual wrote a note of dispute regarding the reimbursement of intraoperative monitoring.

Disputed Services:

Somatosensory studies on 06/09/05

Decision:

I agree with the requestor. The somatosensory studies on 06/09/05 were reasonable and medically necessary.

Rationale/Basis for Decision:

The patient did require intraoperative neural physiological monitoring, including the evoked potential testing, which included somatosensory evoked potentials. This was a clinically indicated procedure and standard of care for a cervical operation of this magnitude. Therefore, in my opinion, the somatosensory studies on 06/09/05 were medically necessary for intraoperative monitoring for the patient.

The rationale for the opinions stated in this report are based on clinical experience and standards of care in the area as well as broadly accepted literature which includes numerous textbooks, professional journals, nationally recognized treatment guidelines and peer consensus.

This review was conducted on the basis of medical and administrative records provided with the assumption that the material is true and correct.

This decision by the reviewing physician consulting for Professional Associates is deemed to be a Division decision and order.

YOUR RIGHT TO REQUEST A HEARING

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 Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision. A request for a hearing should be faxed to 512-804-4011 or sent to:

Chief Clerk of Proceedings/Appeals Clerk
TDI-Division of Workers' Compensation
P. O. Box 17787
Austin, TX 78744

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

I hereby verify that a copy of this Independent Review Organization's decision was sent to DWC via facsimile or U.S. Postal Service on 04/12/06 from the office of Professional Associates.

Sincerely,

Lisa Christian
Secretary/General Counsel