



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.: M5-06-1230-01
Dr. Glenn J. Bricken 25810 Oak Ridge Drive The Woodlands, Texas 77380	Claim No.:
	Injured Worker's Name:
Respondent's Name: Texas Mutual Insurance Company Rep Box # 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position Summary: "The services provided were not unbundled."
 Principle Documentation: 1. DWC-60 package
 2. CMS 1500s
 3. EOBs
 4. Preauthorization approval letter

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position Summary: The position statement submitted by Texas Mutual does not address the disputed services.
 Principle Documentation: 1. DWC-60 response

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Amount Due
03-22-05	99080 (3 page narrative)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$ 70.00
04-05-05	99080 (2 page narrative)		\$ 50.00
05-31-05	99080 (4 page narrative)		\$ 90.00
TOTAL DUE			\$210.00

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 (MDR) 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, MDR 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 MDR.

On 4-18-06, MDR 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.

CPT code 90801 billed for DOS 03-01-05 was denied by the Respondent with denial codes "24" (Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan) and "793" (Reduction due to PPO contract...applied by National Choice Care.) The Respondent made an initial payment of \$157.08 and upon reconsideration, the Respondent made a supplemental payment of \$ 27.72 for a total payment of \$184.80. The Requestor confirmed that he does have a contract with National Choice Care, therefore, Medical Dispute Resolution does not have jurisdiction in this matter.

CPT code 90885 billed for DOS 03-01-05 was denied by the Respondent with denial codes "97" (payment is included in the allowance for another service/procedure), "W1" (Workers Compensation State Fee Schedule Adjustment), "284" (no allowance was recommended as this procedure indicates a status B (bundled) based on Medicare) and "790" (this charge was reduced in accordance to the Texas Medical Fee Guideline). Per Rule 134.202 CPT code 90885 is a bundled code. No reimbursement is recommended.

CPT code 90887 billed for DOS 03-01-05 was denied by the Respondent with denial codes "97" (payment is included in the allowance for another service/procedure), "W1" (Workers Compensation State Fee Schedule Adjustment), "284" (no allowance was recommended as this procedure indicates a status B (bundled) based on Medicare) and "790" (this charge was reduced in accordance to the Texas Medical Fee Guideline). Per Rule 134.202 CPT code 90887 is a bundled code. No reimbursement is recommended.

CPT code 90889 billed for DOS 03-01-05 was denied by the Respondent with denial codes "97" (payment is included in the allowance for another service/procedure), "W1" (Workers Compensation State Fee Schedule Adjustment), "284" (no allowance was recommended as this procedure indicates a status B (bundled) based on Medicare) and "790" (this charge was reduced in accordance to the Texas Medical Fee Guideline). Per Rule 134.202 CPT code 90889 is a bundled code. No reimbursement is recommended.

CPT code 90901 billed for DOS 04-05-05 was denied by the Respondent with denial codes "24" (payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan) and "793" (Reduction due to PPO contract...applied by National Choice Care). The Respondent made an initial payment of \$40.28 and upon reconsideration a supplemental payment of \$ 7.11 for a total payment of \$47.39. The Requestor confirmed that he does have a contract with National Choice Care, therefore, Medical Dispute Resolution has no jurisdiction in this matter.

CPT code 90806 billed for DOS 05-20-05 was denied by the Respondent with denial codes "62" (payment denied/reduced for absence of, or exceeded, pre-certification/authorization), "930" (pre-authorization required. Reimbursement denied), "W4" (no additional reimbursement allowed after review of appeal/reconsideration) and "891" (the insurance company is reducing or denying payment after reconsidering a bill). The Requestor submitted copy of preauthorization approval letter dated 03-22-05 which authorized eight individual psychotherapy sessions over 10 weeks. Reimbursement per Rule 134.202(c)(1) is recommended in the amount of **\$119.75**.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.031
28 Texas Administrative Code Sec. 134.1, 133.308, 133.106, 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 reimbursement of \$329.75. 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 \$460.00. 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:

11-06-2006

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.

MATUTECH, INC.

**PO Box 310069
New Braunfels, TX 78131
Phone: 800-929-9078
Fax: 800-570-9544**

May 1, 2006

Texas Department of Insurance
Division of Workers' Compensation
Fax: (512) 804-4001

Re: Medical Dispute Resolution
MRD#: M5-06-1230-01
DWC#:
Injured Employee:
DOI:
IRO Certificate No.: IRO5317

Dear Ms. ____:

Matutech, Inc. has performed an Independent review of the medical records of the above-named case to determine medical necessity. In performing this review, Matutech reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

Matutech certifies that the reviewing healthcare professional 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.

Information and medical records pertinent to this medical dispute were obtained from Dale Billing Resources. The Independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is licensed in chiropractics, and is currently on the DWC Approved Doctor list.

Sincerely,

John Kasperbauer
Matutech, Inc.

REVIEWER'S REPORT

Information provided for review:

Request for Independent Review

Information provided by Dale Billing Resources:

Clinic notes (03/02/05 through 07/05/05)

Clinical History:

This is a 42-year old female who suffered a left foot injury when she tripped over a stump.

On March 2, 2005, the patient underwent a psychological evaluation for depression and anxiety secondary to the chronic pain condition. Glenn Bricken, Psyh. D., noted that the patient had undergone two tarsal tunnel release surgeries on her left foot; the first one in November 2003 and the second in June 2004. However, her pain had increased after the surgeries and she also had no relief with the injections. Her medications were Elavil, Bextra, Neurontin, and Darvocet. The patient reported that she had recently separated from her husband due to depression. She had an inability to participate in activities and had loss of sexual interest. Her pain led to suicidal thoughts. Dr. Bricken assessed mood and anxiety disorder and chronic pain disorder associated with the left foot injury. Eight individual psychotherapy sessions and one biofeedback evaluation was requested prior to the consideration of a chronic pain management program (CPMP). Dr. Bricken later recommended eight self-hypnosis training sessions including biofeedback. In March 2005, the request for biofeedback evaluation was resubmitted. The patient underwent one individual psychotherapy and biofeedback session. She responded well to biofeedback/hypnotherapy training. Dr. Bricken requested eight hypnotherapy sessions including biofeedback.

Samuel Allianell, M.D., a physiatrist, noted complaints of low back pain. He noted that the patient had been treated by Dr. Thomas Reed, a podiatrist. Following the surgeries, the patient's symptoms had increased. She also had had injections to her back and had received several cortisone injections to her heel. Dr. Allianell recommended a trial of Effexor XR for depression and anxiety. He refilled Elavil, Neurontin, and Darvocet. He recommended an outpatient multidisciplinary CPMP. The patient reportedly had attended eight individual psychotherapy and relaxation/biofeedback sessions. The patient responded reasonably well to the treatment but had only made limited progress in reducing her frustration, symptom magnification, and pain. Dr. Bricken recommended CPMP for 20 days. In August 2005, Dr. Bricken stated that the patient had actively participated in 19 days of CPMP and had been 100% compliant with treatment. The patient had approximately 50% reduction in her depression and a 33% reduction of her anxiety. Dr. Bricken requested final 10 days of CPMP.

On January 12, 2006, the Dale Billing resources provided a position statement this case. The following was reported: The carrier had denied narratives reports (99080) dated 3/22/05, 4/5/05, and 5/31/05, as "unbundled". The carrier had also denied the claim for an individual psychotherapy session dated 5/20/05 (fifth session) for the absence of preauthorization although, eight sessions over 10 weeks up to 5/31/05 had already been approved by Texas Mutual. A reconsideration request for the same was also denied.

Disputed Services:

Special Reports/Narratives (99080)
(Dates of Service: 03/22/05, 04/05/05, & 05/31/05)

Explanation of Findings:

According to the medical records provided, the claimant underwent individual psychotherapy sessions on 3-22-05, 4-5-05, and 5-31-05. According to DWC rule 133-104, a consulting doctor shall submit a narrative report to the carrier, the injured employee, and/or injured employee's representative within 10 days of the examination. The reports in dispute were narrative reports that the referral doctor by the previously stated rule had to submit per rule. Thus, the previous decision should be overturned and the narrative reports are medically necessary.

Conclusion/Decision To Uphold, Overturn or Partially Uphold/Overturn denial:

Overturn

Applicable Clinical of Scientific Criteria or Guidelines Applied in Arriving at Decision:

DWC rule 133.104

The physician providing this review is a chiropractor. The reviewer is national board certified in chiropractic. The reviewer has been in active practice for seven years.

Matutech is forwarding this decision by mail and in the case of time sensitive matters by facsimile to the Texas Department of Insurance, Division of Workers Compensation.

Matutech retains qualified independent physician reviewers and clinical advisors who perform peer case reviews as requested by Matutech clients. These physician reviewers and clinical advisors are independent contractors who are credentialed in accordance with their particular specialties, the standards of the Utilization Review Accreditation Commission (URAC), and/or other state and federal regulatory requirements.

The written opinions provided by Matutech 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 Matutech for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Matutech 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. 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.

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.