



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: Buena Vista Workskills 5445 LaSierra Ste 204 Dallas, Texas 75231	MDR Tracking No.: M5-06-1251-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Insurance Company of the State of PA Rep Box # 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: The Requestor did not submit a Position Summary to MDR.

Principle Documentation:

1. DWC-60/Table of Disputed Services
2. CMS 1500's
3. Explanation of Benefits

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: ... "The carrier has disputed that the injury extended beyond minor musculoskeletal trauma, as explained by its RME, Dr. Marc T. Taylor, M.D..."

Principle Documentation: Response to DWC-60

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
08-19-05	90801 (\$184.80 per unit X 5 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$924.00
08-19-05 & 10-12-05	97750 (1 unit @ \$35.63 X 9 units)(6 units 8-19-05 & 3 units 10-12-05)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$320.67
09-23-05	96151 (1 unit @ \$30.73 X 2 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$61.46
11-11-05	96152 (0.5 units @ \$14.68 X 1 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$14.68
TOTAL			\$1,320.81

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.

Based on review of the disputed issues within the request, Medical Dispute Resolution 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 06-02-06, Medical Dispute Resolution 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 97799-CPCA billed on dates of service 09-08-05 through 10-20-05 (117 units total billed) was denied by the Respondent with denial code "U" (The carrier is denying payment for any medical treatment, diagnostic testing or prescriptions after 1/15/2004 based on the results of a Required Medical Examination to indicate further medical treatment is not necessary). The Requestor requested and obtained preauthorization (preauthorization numbers 6600-01-0045JKC-15 and

6600-01-0045JKC-16) for chronic pain management prior to the services being rendered. Reimbursement per Rules 134.600 and 134.202 is recommended in the amount of **\$14,625.00 (\$125.00 X 117 units billed)**.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.1, 134.202 and 134.600
Texas Labor Code, Sec. 413.031 and 413.011 (a-d)

PART VII: DIVISION FINDINGS 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 in the amount of \$15,945.81. 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 Respondent 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:

08-16-06

Authorized Signature

Typed Name

Date of Findings and Decision

Order by:

08-16-06

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

July 21, 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 #: M5-06-1251-01
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 while working as a housekeeper, she fell down the stairs while carrying some heavy objects, injuring her lower back. The patient has been treated with chronic pain management program and a work hardening program.

Requested Service(s)

(90801) Psychiatric diagnostic interview examination, (97750) Physical performance test, (96151) Health and behavior assessment, (96152) Health and behavior intervention provided from 08/19/05 to 11/11/05

Decision

It is determined that the (90801) Psychiatric diagnostic interview examination, (97750) Physical performance test, (96151) Health and behavior assessment, (96152) Health and behavior intervention provided from 08/19/05 to 11/11/05 were medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The patient assessment dated 09/19/05 revealed that she rated her pain level a 7/10 at the time of the evaluation with elevations to 9/10 within the past 6 months. Her pain level interfered with her recreational, social and familial activities. She reported a variety of physiological changes and symptoms to include: change of appetite, muscle spasms/tension, numbness, frequent stomach problems, frequent headaches, feeling tired and weak all over, waking up often during the night, suffering from constant pain, and often needing medication to relieve her pain and guarding/bracing behaviors. Her mood is depressed and anxious. She further reported symptoms indicative of injury related mood disturbance including: moodiness, unusual avoidance of risk, unrealistic fears or widespread feeling of discomfort, feeling of hopelessness towards the future, excessive worry over health, future events, potential re-injury, nightmares or recurrent thoughts about injury related problems, being jumpy or easily startled, having a feeling of panic or dread, lack of enjoyment and feeling of satisfaction with life, becoming easily angered, always feeling tired or not well, and an inability to relax or feeling as though she is under constant strain and periods of brooding or silence. She was also referred for a physical performance evaluation to assess her current physical condition.

In summary, she had received on going care for an extended period of time. She continued to experience injury related problems. The appropriate action for her treating doctor was to refer her for the psychiatric diagnostic interview examination (90801) and physical performance test (97750). These evaluations revealed continued significant psychological and physical deficits that required an interdisciplinary pain management program. In addition the physical performance test on 10/12/05, the health and behavior assessment (96151) on 09/23/05, and the health and behavior intervention (96152) on 11/11/05 were clinically justified to document the patient's response to her interdisciplinary pain management program.

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,

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

Attachment

Information Submitted to TMF for Review

Patient Name: Tracking #: M5-06-1251-01

Information Submitted by Requestor:

- **Letter of Medical Necessity**
- **Behavioral Medicine Re-Evaluation**
- **Chronic Pain Management Daily Notes**
- **Work Hardening Daily Flow Sheet**
- **Group Psychotherapy Progress Notes**
- **Pain management group notes.**
- **Massage Therapy Notes**
- **Individual Psychotherapy Notes**
- **Biofeedback Therapy Notes**
- **Physical Performance Evaluation**
- **Interdisciplinary Pain Rehabilitation Discharge Summary**

Information Submitted by Respondent:

None