



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.: M5-06-1514-01
Health and Medical Practice Associates 324 N. 23 rd St. Ste. 201 Beaumont, TX 77707	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:
TX Mutual Insurance Company, Box 54	

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. CMS-1500's
3. EOB's

Position summary states, "Based in the above information, I am requesting you initiate payment of the billing for the above dates of service. The services rendered are well within acceptable standards of care."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response. Position summary states, "Texas Mutual requests that the request for dispute resolution filed be conducted under the provisions of the APA."

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)
6-29-05 – 9-21-05	97032 (\$19.09 X 56 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,069.04
6-29-05 – 9-21-05	95904 (\$63.75 X 10 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$637.50
6-29-05 – 9-21-05	97124 (\$26.73 X 12 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$320.76
6-29-05 – 9-21-05	97530 (\$35.34 X 6 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$212.04
	Grand Total		\$2,239.34

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 \$2,239.34.

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 5-11-06 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.

Services from 9-16-05 – 9-21-05 were denied by the carrier as “Per 134.801 provider shall not submit a medical bill later than the 05th day after the date of service, for services on or after 9-1-05.” Per Rule 133.20 (b) “A health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.” No reimbursement recommended.

CPT code 95904 on 7-26-05 (6 units) was denied by the carrier as “225 –The submitted documentation does not support the service being billed...” and “16-claim/service lacks information which is as needed for adjudication...” The Requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Reimbursement of \$382.50 (\$63.75 X 6 units) is recommended.

CPT code 95900 on 11-9-05 and CPT code 95904 on 11-23-05 were denied by the carrier as “225 –The submitted documentation does not support the service being billed...” and “16-claim/service lacks information which is as needed for adjudication...” The Requestor stated in a letter dated January 12, 2006, “We have corrected the code using modifier “59” due to signify that this is an additional procedure.....” However, request for reconsideration must have the identical codes and charges that are on the original medical bill per 133.304(k)(1)(B). No additional reimbursement is recommended.

CPT code 95900 on 11-23-05 (4 units) was denied by the carrier as “97-Payment is included in the allowance for another procedure. The Requestor stated in a letter dated January 12, 2006, “We have corrected the code using modifier “59” due to signify that this is an additional procedure.....” Request for reconsideration must have the identical codes and charges that are on the original medical bill per 133.304(k)(1)(B). No additional reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.20 (b), 133.304(k)(1)(B), 133.307, 134.801, 133.308 and 134.202(c)(1)
Texas Labor Code 413.031

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 \$2,621.74. 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:

July 24, 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.

NOTICE OF INDEPENDENT REVIEW DECISION

June 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 #: M5-06-1514-01
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 1974. 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 he was unloading a crate of steel that was three to four feet long, weighing approximately 1000 to 1500 pounds when the steel began to fall out of the crate. The patient tried to catch the steel and felt severe pain and pulling sensation in his neck radiating down the mid and low back region. The patient complains of right neck pain and stiffness, right shoulder pain, right arm pain, bilateral low back pain and stiffness, right buttocks pain, decreased cervical lumbar range of motion due to severe pain and stiffness, muscle guarding, and spasms in the cervical lumbar area. The patient was treated with several therapeutic modalities.

Requested Service(s)

(97032) Electrical stimulation, (95904) sensory testing each nerve, (97124) message therapy, (97530) therapeutic activities provided from 06/29/05 through 11/23/05.

Decision

It is determined that (97032) Electrical stimulation, (95904) sensory testing each nerve, (97124) message therapy, (97530) therapeutic activities provided from 06/29/05 through 11/23/05 were medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The medical rationale for electrostimulation treatments two sessions per day would include the necessity for both the cervical and lumbar areas with electrostimulation to each region required. Massage therapy to the cervical and lumbar regions was necessary in order to reduce current physical impairment that the patient was suffering. These impairments limited the patient's ability to engage in normal pain free activities of daily living and impaired the patient's ability to return to useful employment. Therapeutic activities including bicycling, isokinetics, lumbar stabilization stretching would also be appropriate to achieve the goals of improving mobility and restoring the patient's ability to perform normal activities of daily living.

Also an issue is multiple sensory nerve testing (95904). The initial testing of multiple sensory nerves helped establish and confirm the suspected injury to the spine and lumbar area. Additional sensory nerve testing was undertaken on 07/18/05 in order to determine why

the patient's physical therapy modalities were failing to provide response. It was after this additional testing that showed widespread sensory nerve abnormalities in the cervical and lumbar area that additional testing with MRI's was felt necessary. MRI's to the cervical and lumbar area were abnormal. This sensory nerve testing was medically appropriate in order for the treating physicians to assess response and proceed with the therapeutic and diagnostic plan for the patient.

The patient suffered an injury to the cervical and lumbar area. His assessment was complete. His evaluation and plan of treatment meets medical standards for the treatment of these musculoskeletal and spinal injuries. The physical therapy modality plans and the physical therapy received, fall within the guidelines and were medically necessary.

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.

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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

Information Submitted to TMF for Review

Patient Name: ____ **Tracking #:** M5-06-1514-01

Information Submitted by Requestor:

None

Information Submitted by Respondent:

- Preface letter to TMF
- House Bill 2600
- Sensory Nerve Study (Progress Notes)
- Motor Nerve Conduction Velocity Study
- Medicare Part B News Letter
- Report of MRI of the cervical spine
- Report of MRI of the lumbar spine
- Medical Fee Guidelines
- Physiotherapeutic Notes
- Daily Notes Report
- Medical Progress Notes
- Worker's Comp Prescription Forms
- Initial Medical consultation
- Physical examination and Objective Spinal Findings
- Supplemental Follow Up Evaluations
- Functional Capacity Evaluation
- Claims