



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: Debbie Crawford, D.O. 3804 Highway 377 South Brownwood, Texas 76801	MDR Tracking No.: M5-05-2659-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Hartford Underwriters Insurance Box 27	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: TWCC-60, explanation of benefits and CMS 1500s.
POSITION SUMMARY: No record that request for reconsideration was acknowledged. Also the services are appropriately documented.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to TWCC-60
POSITION SUMMARY: None submitted by Respondent

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
12-22-04 to 02-09-05	97110 and 27096	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,090.61

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. The amount due from the carrier for the medical necessity issues equals **\$1,090.61**.

Based on review of the disputed issues within the request, the Medical Review 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 09-22-05, 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 codes 95903-TC, 95904-TC and 95934-TC date of service 12-22-04 denied with denial code "N" (additional documentation required to substantiate procedure and/or charged amount. The requestor did not submit documentation for review. No reimbursement recommended.

CPT code 76005-RT date of service 01-26-05 denied with denial code "F" (the services listed under this procedure code are included in a more comprehensive code which accurately describes the entire procedure(s) performed. Per the 2002 Medical Fee Guideline code 76005-RT is not included in a more comprehensive code billed on the same date of service. Reimbursement is recommended in the amount of **\$251.61**.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308

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 \$1342.22. 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.

Findings and Decision and Order by:

Authorized Signature

10-12-05

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.

Parker Healthcare Management Organization, Inc.

3719 N. Beltline Road, Irving, TX 75038

972.906.0603 972.255.9712 (fax)

Certificate # 5301

August 29, 2005

ATTN: Program Administrator
Texas Workers Compensation Commission

Medical Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100

Austin, TX 78744

Delivered by fax: 512.804.4868

Notice of Determination

MDR TRACKING NUMBER: M5-05-2659-01
RE: Independent review for ____

The independent review for the patient named above has been completed.

- Parker Healthcare Management received notification of independent review on 7.1.05.
- Faxed request for provider records made on 7.1.05.
- TWCC issued and Order for Payment on 7.14.05.
- TWCC issued an Order for Documents on 7.28.05.
- The case was assigned to a reviewer on 8.15.05.
- The reviewer rendered a determination on 8.26.05.
- The Notice of Determination was sent on 8.29.05.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of the following items: therapeutic exercises (97110) and injection of the sacroiliac joint (right) (27096). Dates of service in dispute are 12.22.04-2.9.05. Items noted on table of disputed services as “fee” issues were not reviewed.

Determination

PHMO, Inc. has performed an independent review of the proposed care to determine if the adverse determination was appropriate. After review of all medical records received from both parties involved, the PHMO, Inc. physician reviewer has determined to **overturn the denial** on the disputed service(s).

Summary of Clinical History

Mr. ____ is a 27-year-old gentleman working for the local newspaper with lots of heavy lifting, bending, carrying and walking on concrete. He developed severe lower back pain. He was evaluated and treated by Dr. Debbie Crawford, his primary care physician and pain specialist. He was referred to Dr. LeGrande, a neurosurgeon. He had an MRI and nerve conduction studies performed, both of which were normal.

He proceeded with a physical therapy program and ultimately reached maximal medical improvement with 0% impairment protruding from this and Dr. Crawford then released him to full duty.

Clinical Rationale

After reviewing the detailed information provided by Dr. Crawford's office regarding Medicare guidelines for use of code 97110, it appears that this code is properly and effectively used for billing. Furthermore, in reviewing the case in general, the treatment provided appears to be reasonable and appropriate for that of an acute sprain/strain with an individual that made good participation in treatment. The claimant ultimately returned to work with 0% impairment and did so in approximately 3 month's time, which would be a reasonable time frame for an acute sprain/strain injury.

CONCLUSION: I see no inappropriate use of the code(s) or any inappropriate, excessive, or unnecessary treatment as a result of the injury.

Clinical Criteria, Utilization Guidelines or other material referenced

This conclusion is supported by the reviewers' clinical experience with over 10 years of patient care.

The reviewer for this case is a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical medicine and Rehabilitation, and is engaged in the full time practice of medicine.

The review was performed in accordance with Texas Insurance Code §21.58C and the rules of the Texas Workers Compensation Commission. In accordance with the act and the rules, the review is listed on the TWCC's list of approved providers, or has a temporary exemption. The review includes the determination and the clinical rationale to support the determination. Specific utilization review criteria or other treatment guidelines used in this review are referenced.

The reviewer signed a certification attesting that no known conflicts-of-interest exist between the reviewer and any of the providers or other parties associated with this case. The reviewer also attests that the review was performed without any bias for or against the patient, carrier, or other parties associated with this case.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Tex. Admin. Code § 148.3). This Decision is deemed received by you 5 (five) days after it was mailed and the first working day after the date this Decision was placed in the carrier representative's box (28 Tex. Admin. Code § 102.5 (d)). A request for hearing should be sent to: Chief Clerk of Proceeding/Appeals , P.O. Box 17787, Austin, Texas 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request. The party appealing the Division's Decision shall deliver a copy of this written request for a hearing to the opposing party involved in the dispute.

I hereby verify that a copy of this Findings and Decision was faxed to TWCC, Medical Dispute Resolution department applicable to Commission Rule 102.5 this 29th day of August, 2005. The TWCC Medical Dispute Resolution department will forward the determination to all parties involved in the case including the requestor, respondent and the injured worker. Per Commission Rule 102.5(d), the date received is deemed to be 5 (five) days from the date mailed and the first working day after the date this Decision was placed in the carrier representative's box.

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.