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

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address: Shelby Regional Medical Center 4632 NE Stallings Drive Medical Center Plaza Nacogdoches, TX 75965	MDR Tracking No.: M5-06-0146-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Deep East Texas Self Insurance, Box 01	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 form, medical documentation, Explanations of Benefits and CMS 1500's. Position summary states, "Your company has denied all these claims based on lack of medical necessity only. They were denied by the Adjuster, Jody Shirley (not a doctor, or even a nurse), who has failed to include any evidence to support her determination."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No response received.

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)
10-28-04 – 6-12-05	CPT codes 99282, 99283, 99284, 99285	☒ Yes ☐ No	$773.21

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 $773.21.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 134.202(c)(1).

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 ($650.00) 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 $773.21. 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:

	Donna Auby	12-16-05
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.

November 30, 2005

TDI, Division of Workers' Compensation
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution

MDR #:	M5-06-0146-01
DWC#:	
Injured Employee:	___
DOI:	___
SS#:	___
IRO Certificate No.:	IRO 5055

Dear Ms. ___:

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

I am the Secretary and General Counsel of Independent Review, Inc. and I certify 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 and 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 requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Internal Medicine, and is currently on the DWC Approved Doctor List.

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,

Gilbert Prud'homme
General Counsel
GP:dd

REVIEWER'S REPORT
M5-06-0146-01

___

Information Provided for Review:
DWC-60, Table of Disputed Services, EOB's
Information provided by Requestor:
Correspondence
ER Visits 10/28/04 – 06/12/05
Information provided by Respondent:
Correspondence

Clinical History:
This is a case involving a patient who has had numerous emergency room visits for both migranous headaches as well as neck pain. The patient had been seen by an anesthesiologist as their primary care physician for pain control. Apparently the patient had neck or cervical spine surgery done in 2003, which she is claming had caused pain in her neck as well as frequent migranous headaches.

Disputed Services:
CPT codes 99282, 99283, 99284, 99285 – Emergency department visits for evaluation and management of patient.

Decision:
The reviewer disagrees with the determination of the insurance carrier and is of the opinion the services in dispute as stated above were medically necessary in this case.

Rationale:
I do have some issues with the multiple emergency room visits, but unfortunately, secondary to a lack of documentation, basically only the emergency room notes, the patient was in pain. There is notation stating that the patient did try other methods, which were not specified, to improve the pain prior to going to the emergency room. Also there is no documentation from the patient's primary care physician or pain doctor stating that other methods other than going to the emergency room were made available to her. Yes, there were medications that were started such as Calan as well as a Duragesic patch, but once again, it is not clear from the documentation that has been presented that the patient was counseled about the numerous emergency room visits. Other methods were made available to her so that she did not have to go to the emergency room when she did for her pain. At this point, from the documentation here, it is impossible to make a determination whether the patient's neck injury played a role in her headaches or not. It could be either possible or not possible, but again, the documentation is fairly sparse.