



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 Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address: Judson J. Somerville, M.D. 6801 McPherson Avenue, Suite # 334 Laredo, Texas 78041	MDR Tracking No.: M5-06-0165-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Fidelity & Casualty Company Rep Box # 47	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: "...The carrier has paid sporadically for previous morphine pump refills. Why did they suddenly decide that the treatment was no longer medically necessary? There seems to be no rhyme or reason for the denials...."

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 services in this dispute were denied by Carrier citing, "V-unnecessary treatment per peer review." See EOBs, at Exhibit A. While Provider states on his table of disputed services as his "rationale for reimbursement" that the services were preauthorized, Carrier did not in fact preauthorize the services provided on date of service 1/14/05. In fact, Carrier would not have issued preauthorization for these services because the services billed on date of service 1/14/05 do not require preauthorization...."

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)
11-19-04	99214	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$96.91
11-19-04	62368 (see note below regarding reimbursement)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	DOP
11-19-04	A4220 (see note below regarding reimbursement)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	DOP
11-19-04	J2271 (1 unit)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$8.74
11-19-04	J1230 (1 unit)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$0.85
11-19-04	95990	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$64.54
	TOTAL		\$171.04 + DOP

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.

Note: Texas Labor Code 413.011 (d) and Rule 133.304 (i) (1-4) place certain requirements on the Requestor when billing for services (DOP) for which the Commission has not established a maximum allowable reimbursement. Per Rule 133.307(g)(3)(D), the Requestor is required to discuss, demonstrate and justify that the payment being sought is a fair and reasonable rate of reimbursement. The Requestor has provided sample EOBs or other evidence that the fees billed are for similar treatment of injured individuals and that reflect the fee charged to and paid by other carriers. Recommend reimbursement per Rule 134.202(c)(6).

The Division has reviewed the enclosed IRO decision and determined that the Requestor **prevailed** on the disputed medical necessity issues.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.202, 134.202(c)(6), 133.304(i)(1-4), 133.307(g)(3)(D)
Texas Labor Code, Sec. 413.011 (a-d) and Sec. 413.031

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 in the amount of \$171.04 + DOP. 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 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.

Ordered by:

08-07-06

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.

July 13, 2006

ATTN: Program Administrator
Texas Department of Insurance/Workers Compensation Division
7551 Metro Center Drive, Suite 100
Austin, TX 78744
Delivered by fax: 512.804.4868

Notice of Determination

MDR TRACKING NUMBER: M5-06-0165-01
RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 6.5.06
- Faxed request for provider records made on 6.5.06
- TDI-DWC issued an Order for Records on 6.15.06
- TDI-DWC issued an Order for Payment on 6.19.06.
- The case was assigned to a reviewer on 7.5.06.
- The reviewer rendered a determination on 7.13.06.
- The Notice of Determination was sent on 7.13.06.

The findings of the independent review are as follows:

Questions for Review

Medical necessity for 99214-office visit code, 62368-implant pump, A4220-refill kit for implantable infusion pump, J2271 and J1230-injections, and 95990- refill of management implant pump for the date of service 11.19.2004.

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 requested service(s).

Summary of Clinical History

Ms. ____ sustained a work related on the job injury on ____, while employed with ____.

Clinical Rationale

As part of the course and scope of treatment of this injured worker, whose date of injury is ____, she had an implantable morphine pump in 2002 that was paid for and considered reasonable and appropriate. The patient was being treated for chronic intractable pain and records reflect that she had been using a pump with morphine for pain control. The refill and subsequent maintenance of the pump should be routine and standard for an already approved pump. The carrier's denial seems to be ludicrous and outside the norm for a previously approved treatment of a surgical implantable pump.

The carrier has indicated a review of Dr. Neil Blauzvern's reports where he indicated that "her high doses of medications were unreasonable and an implantable morphine pump was inappropriate; then stating that a lot of her pain is psychologically based, that there is no need to maintain physiologic pain treatment of the pump." There is always going to be a psychological component associated with pain management.

I do not think that psychological issues negate the responsibility for treatment of physiologic pain, nor do I feel that a peer review position is an appropriate position to determine the best treatment. If the carrier is really concerned about the appropriateness of care, then a required medical exam would be the most reasonable course. Therefore, based on the records I have for review, it appears that the treatment provided is consistent with the intended implantation of the pump. The denial of care seems unreasonable, given the fact that many dollars invested in time and surgery has been spent on getting this pain control device in place.

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 Texas Department of Insurance /Division of Workers' Compensation. In accordance with the act and the rules, the review is listed on the DWC'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 the treating and/or referring 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. 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 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, 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.

I hereby verify that a copy of this Findings and Decision was faxed to Texas Department of Insurance /Division of Workers Compensation applicable to Commission Rule 102.5 this 13th day of July, 2006. The Division of Workers Compensation will forward the determination to all parties involved in the case including the requestor, respondent and the injured worker.

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.