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: Park Cities Spine and Sports Center P.O. Box 549 Colleyville, TX 76034	MDR Tracking No.: M5-06-0194-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Trinity Universal Ins Co of KS, Box 42	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include DWC 60 form, Explanations of Benefits, medical documentation and CMS 1500's. Position summary states, "To date the carrier has not paid any of the disputed claims, nor have they processed all dates for reconsideration. None of my messages were returned."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include DWC 60 Table of Disputed Services, DWC-45 dated 12-12-03 disputing change of treating physician, Employee's approved Request to Change Treating Doctor dated 12-5-03, DWC-21 disputing change of treating physician to Gregory Davidovich, D. C. Position summary (table of Disputed Services) states, "Medically necessary or appropriate care for tarsal tunnel syndrome. Unresolved dispute on change of treating doctor."

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)
2-7-05 – 3-1-05	99213, 97110, 97032, 97140-59	☒ Yes ☐ No	$881.51

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 $881.51.

Services for dates of service 2-7-05 – 3-1-05 were also denied by the carrier as "855-015- Service provided by the referral health care provider was not approved by the treating physician." A DWC-53 approved on 12-05-03 shows that Dr. Davidovich was the treating doctor on this date of service. Medical documentation shows that he is the physician who performed these services.

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 10-13-05 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 code 99213 on 9-29-04 was denied by the carrier as "855-015 - Service provided by the referral health care provider was not approved by the treating physician." A DWC-53 approved on 12-05-03 shows that Dr. Davidovich was the treating doctor on this date of service. Medical documentation shows that he is the physician who performed this service. Recommend reimbursement of $68.24.

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 parties are instructed to review the IRO decision and take appropriate action. 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 $949.75. 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:

		11-21-05
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 11, 2005

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

Re: Medical Dispute Resolution
MDR #: M5-06-0194-01
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 chiropractic, 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
M5-06-0194-01

Information Provided for Review:
DWC-60, Table of Disputed Services, EOB's
Information provided by Requestor:
- Office Notes 12/22/03 – 02/07/05
- PT Notes 02/09/05 – 03/02 05
- EMG Study 01/27/04
- Radiology Reports 08/03/02 – 04/28/04

Information provided by Respondent:
- Designated Reviews

Orthopedics:
- Office Notes 07/09/02 – 03/30/05
- OR Reports 08/22/02 – 01/20/05

Clinical History:
As the record indicates, the patient was originally injured on the job on ___ in a work-related injury. She was evaluated, and the treatment program was begun. Over a period of time, she has had an MRI scan to confirm her problem as well as treatment in form of therapy, medications, injections, as well as surgical intervention. She continued to experience ongoing problems and requested a change of treating doctors.

Disputed Services:
Office visits 99213, therapeutic exercises 97110, electrical stimulation 97032, and manual therapy technique 97140-59, dates of service 02/07/05 through 03/01/05.

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:
Records indicate that the patient was originally injured and received a tremendous amount of treatment. However, she continued to have ongoing problems, and she sought change of treating doctors. She continued to experience difficulty, which led to additional diagnostic testing and additional surgical intervention on her right knee. Surgical intervention was performed on 01/20/05. Two weeks after her right knee arthroscopy, the surgeon referred the patient to begin formal therapy. This therapy is the point of the denied services. I have reviewed the records that indicate the services performed were, in fact, usual, reasonable, customary, and medically necessary for treatment of this patient's injuries. The national treatment guidelines allow for this type of post surgical rehabilitation. There is sufficient documentation to clinically justify all treatment that was rendered. In conclusion, all denied services were, in fact, medically necessary for the treatment of this patient's on-the-job injury.