



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: Dr. Patrick R.E. Davis 115 W. Wheatland Road Ste 101 Duncanville, Texas 75116	MDR Tracking No.: M5-06-1228-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: American Home Assurance Rep Box # 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60 dispute package
POSITION SUMMARY: Per the Table of Disputed Services "Documentation supports medical necessity"

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60
POSITION SUMMARY: "This is a fee dispute involving retrospective medical necessity. The carrier disputes that the provider has shown that the treatment underlying the charges was medically reasonable and necessary".

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
05-18-05 to 06-10-05	99215, 99215-59, 98940, 98940-59, 97140-59, 97112-59, 97116-59, E0745, E1399-NU, 97035, 97035-59 and 97110-59	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00

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 **not** prevail on the disputed medical necessity issues.

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 06-15-06, 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.

HCPCS code L0515 billed on date of service 05-19-05 is an invalid code per the 2005 DMEPOS Fee schedule. No reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 2005 DMEPOS Fee schedule

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 Division has determined that the requestor is not entitled to reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

07-06-06

Authorized Signature

Typed Name

Date of Findings and Decision

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.

June 2, 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: M5-06-1228-01
RE: Independent review for _____

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

- Parker Healthcare Management received notification of independent review on 4.13.06 via UPS.
- Faxed request for provider records made on 4.14.06.
- TDI-DWC issued an Order payment on 4.24.06.
- The case was assigned to a reviewer on 5.17.06.
- The reviewer rendered a determination on 6.2.06.
- The Notice of Determination was sent on 6.2.06.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of OV-99215, 99215-59; chiro man 98940, 98940-59; manual therapy 97140-59; neuro-muscular reeducation 97112-59; gait training 97116-59; neuromuscular stimulator E0745RR, TENS pads for EMS E1399-NU; ultrasound 97035, 97035-59; and therapeutic exercise 97110-59. The dates in dispute are 5.18.05-6.10.05.

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 **uphold the denial** on the requested service(s).

Summary of Clinical History

Patient underwent examinations and physical medicine treatments after sustaining injury at work on ____.

Clinical Rationale

The 03.30.06 letter from the carrier's law firm states "*SOAH decisions have held that documentation that is 'too perfunctory to allow any reasonable assessment of the necessity for the care in question' does not meet relevant proof requirements.*" It then gives "SOAH docket no. 453-02-0533.M5" as the reference for the carrier's denial. That basis cannot be relied upon since the referenced SOAH decision cannot be verified on the TDI Division of Workers' Compensation website nor after extensive Internet searches.

The SOAH decision notwithstanding, there is less than adequate information to document the medical necessity of disputed treatment because there were no treatment or examination records for the time period in question. In fact, the last treatment record supplied by the provider for this claimant was dated 11.19.04.

Clinical Criteria, Utilization Guidelines or other material referenced

- Texas Labor Code 408.021

This conclusion is supported by the reviewers' clinical experience with over 8 years of patient care.

The reviewer for this case is a doctor of chiropractic peer matched with the provider that rendered the care in dispute. The reviewer is engaged in the practice of chiropractic on a full-time basis.

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 (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. The address for the Chief Clerk of Proceedings would be: P.O. Box 17787, Austin, Texas, 78744.

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 2nd day of June, 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.