



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	
Requestors Name and Address: Dr. Debbie Crawford 3804 Highway 377 South Brownwood, Texas 76801	MDR Tracking No.: M5-06-1648-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Texas Hospital Insurance Exchange Rep Box # 06	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: Per the Table of Disputed Services "Medically necessary based on documentation".

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: None submitted by Respondent

Principle Documentation: Response to DWC-60 including copy of peer review

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
06-28-05 & 06-29-05	90782, J0702, J1100, J1030, J1885, J2001, J2800, J7050, G0347, 72114-TC, 72170-TC, 76005, 27096 and 64445	<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.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308
Texas Labor Code, Sec. 413.031

PART VII: DIVISION FINDINGS AND 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:

07-26-06

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.

July 7, 2006
Amended: July 12, 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: M5-06-1648-01
RE: Independent review for _____

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

- Parker Healthcare Management received notification of independent review on 6.1.06.
- Faxed request for provider records made on 6.1.06.
- The case was assigned to a reviewer on 6.20.06.
- The reviewer rendered a determination on 7.7.06.
- The Notice of Determination was sent on 7.7.06.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of CPT codes 90782-therapeutic, diagnostic or prophylactic injection, J0702-Betamethasone injection; J1100 Dexamethasone injection; J1030 Methylprednisolone acetate 40 mg injection; J1885-Ketorolac Tromethamine per 15 mg injection; J2001-Lidocaine HCl 10 mg; J2800-Methocarbamol injection; J7050-infusion of saline solution; G0347-intravenous infusion for therapy, prophylaxis or diagnosis up to 1 hour; Xrays-72114, 72170; 76005-therapeutic injection procedure; 27096-therapeutic injection procedure and 64445-injection anesthetic agent
Dates in question: 6.28.05 and 6.29.05

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

Debbie Crawford practices at the _____ and she has notes regarding _____ indicating that the patient was injured on ____ and it appears she was denied dates of service of 06/28/2005 and 06/29/2005. She states that Ms. _____ is in a chronic pain management program. She has been weaned off narcotic medications, but still has non-narcotic medications and will need those for an undetermined amount of time in the future. Ms. _____ has 5 months of a work hardening program, although there were only a total of 20 sessions. She reports that Ms. _____ has been compliant with all the programs; however, there have been gaps in her care.

On the morning of 06/28/2005 she awoke with severe pain in her mid thigh and right leg and couldn't participate in the work hardening program because of severe pain. A physical exam was done and a right sciatic nerve block was performed. She was given medication to decrease her severe spasms. She also received an SI joint injection for pain over the right SI joint.

Clinical Rationale

The records reflect an individual with lumbar radicular pain syndrome in a work hardening program from an injury dating back to ____; and the dates in question are 06/28/2005 and 6/29/2005. She had acute paroxysm of pain and it was not an emergency and without preauthorization or approval, multiple injections were performed with unclear indications in my medical opinion. Certainly the patient was having increased pain, but there is not a clear clinical indication why SI joint injections and sciatic nerve blocks were performed. The physician has indicated that she wants to take this to medical dispute resolution. The documentation provided does not support an overturn of the carrier's denial of these services.

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 7th 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.