



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

|   |                                 |
|---|---------------------------------|
| <b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier |                                 |
| Requestor's Name and Address:   | MDR Tracking No.: M5-06-1723-01 |
| Matagorda County Hospital<br>1115 Avenue G.<br>Bay City, Texas 77414                          | Claim No.:                      |
|   | Injured Employee's Name:        |
| Respondent's Name and Address:  | Date of Injury:                 |
| Texas Mutual Insurance Company, Box 54  | Employer's Name:                |
|   | Insurance Carrier's No.:        |

#### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary (Table of Disputed Services) states, "Physician referred patient to emergency room due to diagnosis."

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. CMS-1500's
3. EOB's

#### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position statement submitted by Texas Mutual does not address the disputed issues.

Principle Documentation:

1. DWC-60/Table of Disputed Service

#### 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)    |
|--------------------|--|---|-----------------------------------|
| 8-03-05            | 93005  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$19.69                           |
| 8-03-05            | 71010  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$32.00                           |
| 8-03-05            | 84484 - DOP code   | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | per Rule 134.202 (c)(6)           |
| 8-03-05            | 93005-76   | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$19.69                           |
| 8-03-05            | 71275, 85025, 36415, 85378, 85610, 85730, 80053, 83735, 82550, 83880, 82553, 80101, 80101-91, 99285-25, 90784, catheter-IV, aspirin, warfarin sod, acetaminophen/Hydroco, morphine sulfate, nitroglycerin, lovenox syringe, enoxaparin - 60 mg, IV start kit, interlink catheter extension | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | \$0.00                            |
|                    | Total Due  |   | \$71.38 + per Rule 134.202 (c)(6) |

**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 majority of the disputed medical necessity issues. The amount due the Requestor for the items denied for medical necessity is \$71.38 + per Rule 134.202 (c)(6).

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. 133.308, 134.1 and 134.202  
Texas Labor Code 413.011 and 413.031

**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 a refund of the paid IRO fee. The Division has determined that the Requestor is entitled to reimbursement for the services involved in this dispute in the amount of \$71.38 + amount per Rule 134.202 (c)(6). 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.

Findings and Decision and Order by:

Medical Dispute Officer

05-30-07

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 25, 2006

AMENDED OCTOBER 1, 2006

Re: MDR #: M5 06 1723 01 Injured Employee:  
DWC #: DOI:  
IRO Cert. #: 5340

**TRANSMITTED VIA FAX TO:**  
**TDI, Division of Workers' Compensation**

Medical Dispute Resolution  
Fax: (512) 804-4868

**RESPONDENT: Texas Mutual**

**REQUESTOR: Matagorda County Hospital**

**TREATING DOCTOR: George Hanna, MD**

In accordance with the requirement for DWC to randomly assign cases to IROs, DWC assigned this case to ZRC Medical Resolutions for an independent review. ZRC has performed an independent review of the medical records to determine medical necessity. In performing this review, ZRC 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 president of ZRC Medical Resolutions, Inc. and I certify that the reviewing physician 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. Your case was reviewed by a physician who is a board certified in Internal Medicine, with a sub-specialty in pulmonary disease, and is currently listed on the DWC Approved Doctor List.

This decision by ZRC Medical Resolutions, Inc. is deemed to be a DWC decision and order.

**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.

Sincerely,

Jeff Cunningham, DC  
President

**P.O. Box 855**  
**Sulphur Springs, TX 75483**  
**903.488.2329 \* 903.642.0064 (fax)**

REVIEWER'S REPORT  
M5 06 1723 01

**Information Provided for Review:**

1. Medical dispute resolution, 6 pages.
2. Statements from Dr. George P. Hanna, 4 pages.
3. Additional pages from Matagorda County Hospital for a total of 58 pages reviewed.

**Clinical History:**

The claimant is a 41-year-old man who in . was struck in the chest with a steel rod and taken to Polly Ryan Hospital where he was shortly discharged. The following July 2005 he was taken to Gulf Memorial Hospital with a complaint of chest pain. He states that he was diagnosed as having a pulmonary embolism, and apparently he was given anticoagulants. The information from Memorial Hospital is not present. On 08/05/05 he went to Matagorda County Hospital with a complaint of chest pain, which was variously described as acute and chronic over the previous 4 days. It was also stated that motion of his arm aggravated the pain. Multiple studies were done in the time he was at the emergency room, which included normal laboratory chemical studies including normal troponin levels and normal CT scan, normal electrocardiogram, and normal blood oxygen. All of this indicated the absence of pathology, and he was subsequently discharged.

**Disputed Services:**

The determination of the insurance company was that the emergency admission was not justified.

**Decision:**

I PARTIALLY AGREE WITH THE DETERMINATION MADE BY THE UTILIZATION REVIEW AGENT ON THIS CASE.

IT WAS REASONABLE AND NECESSARY FOR EKG (93005), EKG MONITORING (93005-76), CHEST X-RAY (71010), SaO2 AND SERUM TROPONIN (84484). ALL OTHER SERVICES WERE NOT MEDICALLY NECESSARY.

**Rationale:**

I agree, in part, with this determination in the absence of any supporting data regarding the possibility or likelihood of pulmonary embolism in mid-July of 2005. All of the studies, which were extensive, were normal and did not indicate any cardiopulmonary abnormality, although it is possible that he could have had a pulmonary embolism 2 weeks earlier, which had completely resolved. There was no indication of current pathology during his ER visit of August, 2005. If the chest pain were actually acute, EKG and temporary EKG monitoring along with a chest X-ray, SaO2 and serum troponin would be medically necessary. History and findings did not indicate the medical need for any additional studies in the presence of the normal findings of the above mentioned tests.

**Screening Criteria/Literature:**

TMF Guidelines/46 years of clinical practice