



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:	MDR Tracking No.: M5-06-1751-01
North Texas Pain Recovery Center 6702 West Poly Webb Road Arlington, Texas 76016	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
Liberty Mutual Fire Insurance, Box 28	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary (Table of Disputed Services) states: "Preauth is not required for a Pain Management Eval."

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 summary (Table of Disputed Services): states, "Denied per peer review...Patient did not have job to return to..."

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. Peer Review

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)
1-18-06	96150 (16 units @ \$32.63)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$522.08
1-23-06 – 1-31-06	97545-WH-CA (1 unit @ \$128.00 X 5 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$640.00
1-23-06 – 1-31-06	97546-WH-CA (1 unit @ \$64.00 X 14 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$896.00
Grand Total			\$2,058.08

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 \$2,058.08.

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 6-19-06 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.

CPT code 90885 on 1-20-06 was denied by the carrier as "X170-Preauthorization was required, but not requested for this service," and "X815-This procedure was incidental to the primary procedure and does not warrant separate reimbursement."

This service, which the 2002 MFG defines as, "Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes" does not require preauthorization pre Rule 134.600. Per the 2002 MFG this service is bundled. There will be no separate reimbursement.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d) and 413.031
28 Texas Administrative Code Sec. 134.1, 134.202, 133.308, 134.600

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 Respondent 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 \$2,058.08 plus DOP amount. 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:

9-19-06

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 26, 2006
Amended: September 1, 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: M5-06-1751-01
RE: Independent review for _____

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

- Parker Healthcare Management received notification of independent review on 6.19.06.
- Faxed request for provider records made on 6.19.06.
- The case was assigned to a reviewer on 7.10.06.
- The reviewer rendered a determination on 7.25.06.
- The Notice of Determination was sent on 7.26.06.

The findings of the independent review are as follows:

Questions for Review

The therapy in question includes work hardening (97545-WH), work hardening each additional hour (97545-WH-CA; 97546-WH-CA) and Health and Behavior Assessment (96150). Dates of service in dispute are from 1.18.06-1.31.06.

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 all of the denied service(s).

Summary of Clinical History

The claimant is suffering from a work related injury. She apparently has suffered repetitive stress and has bilateral wrist pain. She has received many different kinds of conservative care, surgical care, injections and tertiary care as well.

Clinical Rationale

The claimant clearly had a job and planned to return to the work force. Her functional capability or PDL was accurately tested as being below what was expected of her, in regards to the job in which she was injured. There were clear psychological variables and factors that were accurately diagnosed. The claimant had a specific outlined plan and improvement was monitored, she had poor improvement so care ceased and she was put into the appropriate pain management program. The work hardening that was administered was appropriate for the time that it was offered and was initially supported as the appropriate avenue of treatment. The care given is supported based upon the documentation available for review.

Clinical Criteria, Utilization Guidelines or other material referenced

- *Occupational Medicine Practice Guidelines*, Second Edition.
- *The Medical Disability Advisor*, Presley Reed MD
- *A Doctors Guide to Record Keeping*, Utilization Management and Review, Gregg Fisher
- *CARF Guidelines*

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, 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 26th day of July, 2006. The determination was amended on the 1st day of September, 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.