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: Dawn C. Batiz, D.C. 10290 Monroe Drive # 308 Dallas, Texas 75229	MDR Tracking No.: M5-06-1838-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Rep Box # 42	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 "pre-authorized."
Principle Documentation:

1. DWC-60/Table of Disputed Services
2. CMS 1500's
3. Explanation of Benefits
4. Copies of preauthorizations

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: The Respondent did not submit a Position Summary to MDR.
Principle Documentation: Response to DWC-60

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
03-17-06, 03-21-06, 03-23-06, 03-28-06, 03-29-06 and 03-30-06	99212 ($40.00 X 6 DOS)	☒ Yes ☐ No	$240.00
03-17-06	G0283 (1 unit @ $14.64)	☒ Yes ☐ No	$14.64
03-17-06	97112 (1 unit @ $35.00)	☒ Yes ☐ No	$35.00
	Total Due For Medical Necessity Issues		$289.64

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.

Based on review of the disputed issues within the request, Medical Dispute Resolution has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained fee issues that were not addressed by the IRO and will be reviewed by Medical Dispute Resolution.

On 07-13-06, Medical Dispute Resolution 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 97124 billed on dates of service 03-21-06, 03-23-06, 03-28-06, 03-29-06 and 03-30-06 (total of 5 units) was denied by the Respondent with ANSI denial code "50" (these are non-covered services because this is not deemed a medical necessity by the payer) and ANSI codes "W12/W4" (Extent of injury. Not finally adjudicated/no additional reimbursement allowed after review of appeal/reconsideration). The Respondent was contacted on 08-24-06 and verification was made that there were no extent issues. The Requestor obtained preauthorization prior to the services in dispute being rendered. Per Rule 134.600 the Respondent is liable for health care that is approved prior to the Requestor providing the service. Per Rule 134.202(c)(1) reimbursement is recommended in the amount of **$144.00 ($28.80 X 5 units).**

CPT code 97530 billed on dates of service 03-21-06, 03-23-06, 03-28-06, 03-29-06 and 03-30-06 (total of 10 units) was denied by the Respondent with ANSI denial code "50" (these are non-covered services because this is not deemed a medical necessity by the payer) and ANSI codes "W12/W4" (Extent of injury. Not finally adjudicated/no additional reimbursement allowed after review of appeal/reconsideration). The Respondent was contacted on 08-24-06 and verification was made that there were no extent issues. The Requestor obtained preauthorization prior to the services in dispute being rendered. Per Rule 134.600 the Respondent is liable for health care approved prior to the Requestor providing the service. Per Rule 134.202 reimbursement is recommended in the amount of **$350.00 ($35.00 X 10 units).**

CPT code 97110 billed on dates of service 03-21-06, 03-23-06, 03-28-06, 03-29-06 and 03-30-06 (total of 20 units) was denied by the Respondent with ANSI denial code "50" (these are non-covered services because this is not deemed a medical necessity by the payer) and codes "W12/W4" (Extent of injury. Not finally adjudicated/no additional reimbursement allowed after review of appeal/reconsideration). The Respondent was contacted on 08-24-06 and verification was made that there were no extent issues. The Requestor obtained preauthorization prior to the services in dispute being rendered. Per Rule 134.600 the Respondent is liable for health care approved prior to the Requestor providing the service. Per Rule 134.202 reimbursement is recommended in the amount of **$700.00 ($35.00 X 20 units).**

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.1,134.202, 134.202(c)(1) and 134.600
Texas Labor Code, Sec. 413.031 and 413.011 (a-d)

PART VII: DIVISION FINDINGS AND ORDER

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 entitled to reimbursement in the amount of $1,483.64. In addition, the Division finds that the Requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of $460.00. 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.

Order by:

		09-14-06
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.

August 17, 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: M5-06-1838-01
RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 7.13.06.
- Faxed request for provider records made on 7.13.06.
- The case was assigned to a reviewer on 7.27.06.
- The reviewer rendered a determination on 8.15.06.
- The Notice of Determination was sent on 8.17.06.

The findings of the independent review are as follows:

Questions for Review

The therapy in dispute includes office visits (99212), electrical stimulation (G0283) and neuromuscular re-education (97112). The dates of service that are listed in dispute are from 3.17.06 through the date of 3.30.06.

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 was injured as a result of a work related injury on the date of ___. The claimant was injured as a result of picking up a child while working as a teacher. Since the time of the accident, the claimant has been given treatment and therapy as well as various forms of diagnostics.

Clinical Rationale

The claimant had medial branch blocks at L5 and S1 on March 13, 2006. It is typical and standard to have a brief period of physical therapy or active care after surgical injections, such as the injections provided on the date of 3.13.06. The injections based upon Dr. Henderson's documentation improved the claimant's condition. His documentation also reflects that the active care being provided afterwards should be encouraged and continued for the brief period that was requested and pre-authorized. It appears that the claimant was doing better after the therapy in question was administered and was ready to return back to work, but Dr. Henderson's documentation reflects that the carrier requested an FCE. The claimant apparently had the FCE and got injured from it and as a result reverted back to how she was at the beginning of her injury. The injections and the therapy in question allowed the claimant to improve and the claimant was ready to return back to work after the provided therapy, as a result, medical necessity was clearly established based upon the Texas Labor Code 408.021.

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

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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 17th day of August, 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.

August 17, 2006

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7551 Metro Center Drive, Suite 100
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_____

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.