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.:
South Coast Spine & Rehabilitation, P.A. 620 Paredes Line Rd Brownsville, Texas 78521	M5-06-1964-01 (current MDR#) M4-05-2504-01 (former MDR#) M5-06-1447-01 (former MDR#) M4-05-0852-01 (former MDR#) M5-06-1450-01 (former MDR#)
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
Royal Indemnity Company Rep Box # 11	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: "This dispute is a medical fee dispute and not a medical necessity dispute. Medical necessity is not an issue in a medical fee dispute according to Rule 133.307(a). Therefore, we are entitled to submit this request."

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: The Respondent did not submit a Position Summary to MDR.

Principle Documentation:

1. Explanation of Benefits

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
03-26-04	99212	☒ Yes ☐ No	$44.16
05-28-04	90801	☒ Yes ☐ No	$175.16
05-28-04	90901 (1 unit @ $47.23 X 4 units)	☒ Yes ☐ No	$188.92
05-28-04	99213	☒ Yes ☐ No	$61.98
05-28-04	96100 (1 unit @ $81.49 X 3 units)	☒ Yes ☐ No	$232.20
05-28-04	90889	☐ Yes ☒ No	$0.00
05-28-04	99361	☐ Yes ☒ No	$0.00
	TOTAL DUE		$702.42

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 **majority** of the disputed medical necessity issues.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.1, 134.202(c)(1) and 134.202(d)(2)
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 $702.42. 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:

		09-15-06
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 30, 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: M5-06-1964-01
RE: Independent review for ___

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

- Parker Healthcare Management received notification of independent review on 8.3.06.
- Faxed request for provider records made on 8.3.06.
- The case was assigned to a reviewer on 8.16.06.
- The reviewer rendered a determination on 8.30.06.
- The Notice of Determination was sent on 8.30.06.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of the office visits (99212/99213), psychiatric interview (90801), preparation to report (90889), medical conference with team (99361), biofeedback training (90901), psycho diagnostic assessment (96100). Dates in dispute 3.26.04 and 5.28.04.

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 the disputed service(s) office visits (99212/99213), psychiatric interview (90801), biofeedback training (90901) and psycho diagnostic assessments (96100) that occurred on 3.26.04 and 5.28.04.

The PHMO, Inc. physician reviewer has also determined to **uphold the denial** on the disputed service(s)
Preparation to report (90889) and medical conference with team (99361) that occurred on 3.26.04 and 5.28.04.

Summary of Clinical History

Mr. ___ sustained a work related on the job injury on ___, while employed with Investors Management Corp.

Clinical Rationale

The claimant had a documented and related need to see the treating doctor on the date of 3.26.04. This included an office visit that was done in order to spend time with the treating or rendering practitioner on that date. This is a reasonable and acceptable service that was provided. There was a psychiatric or psychological interview conducted on the claimant which was appropriately requested as well as biofeedback which is acceptable on the date of 5.28.06. The claimant was chronic and still had documented symptoms that needed to be addressed and psychological services were appropriately accepted and were documented and supported appropriately. The service of preparation of a report is denied. It is understood that preparing a report is part of any service that requires documentation and to bill separately for that is not necessary. Medical conference with team is not supported. It is understood that all services rendered on a patient that is referred from another practitioner should be related back to that doctor and is part of regular treatment and is expected. To bill separately is unnecessary.

Clinical Criteria, Utilization Guidelines or other material referenced

- *Occupational Medicine Practice Guideline, Second Edition*
- *The Medical Disability Advisor, Presley Reed, MD*
- *Texas Labor Code 408.021*

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 30th 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.