



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.: M5-06-1991-01
Injury 1 Treatment Center 5445 La Sierra Drive #240 Dallas, TX 75231	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:
United States Fidelity & Guaranty Co. Box 19	

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

Requestor's Position Summary: Per Requestor's Table of Disputed Services: "Services were preauthorized: 100122302."

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: Respondent states: "Provider did not submit any documentation proving that the disputed services were preauthorized. Without such proof, Carrier is not liable for these services."

Principle Documentation:

1. 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)
08/31/05 – 09/13/05	90880	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$00.00

#### 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.

On 08/28/06, 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 90806 for dates of service 08/31/05 and 09/13/05 was denied by carrier with Denial Code "W9" (Unnecessary medical treatment based on peer review). Requestor received preauthorization for dates 08/04/05 – 09/04/05 under PCID# 1000122302. The services rendered on 09/13/05 are outside this timeframe, therefore no reimbursement is recommended. CPT code 90806 and 90806 is considered to be a component of 90880. There are no circumstances in which a modifier would be appropriate. The services represented by the code combination will not be paid separately. Per Rule 134.202, no reimbursement is recommended.

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

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

**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 reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

Medical Dispute Officer

02/08/07

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.**

# Clear Resolutions Inc.

**An Independent Review Organization**

**3616 Far West Blvd. Suite 337-117**

**Austin, TX 7831**

Amended November 15, 2006

October 27, 2006

TDI-DWC Medical Dispute Resolution

Fax: (512) 804-4868

Delivered via Fax

Patient / Injured Employee \_\_\_\_\_

TDI-DWC \_\_\_\_\_

MDR Tracking #: \_\_\_\_\_

IRO #: \_\_\_\_\_

M5-06-1991-01

5327

Clear Resolutions, Inc. has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI-Division of Worker's Compensation (DWC) has assigned this case to Clear Resolutions for independent review in accordance with DWC Rule 133.308 which allows for medical dispute resolution by an IRO.

Clear Resolutions has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Provider board certified and specialized in Chiropractic Care. The Reviewer is on the DWC Approved Doctor List (ADL). The Clear Resolutions Panel Member/Reviewer is a health care professional who has signed a certification statement stating that no known conflicts of interest exist between the Reviewer 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 carriers health care providers who reviewed the case for decision before referral to IRO America for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

## **RECORDS REVIEWED**

Notification of IRO assignment, information provided by The Requestor, Respondent, and Treating Doctor(s), including but not limited to: including: explanation of benefits, notes from Scott Crockett DO, psychotherapy notes.

## **CLINICAL HISTORY**

This Patient was employed as a forklift operator for \_\_\_\_\_ He lifted a propane tank and carried it 40 yards up an incline to lift it onto a forklift. He felt pain in his low back with radiating pain down his left leg.

## **DISPUTED SERVICE (S)**

Under dispute is the retrospective medical necessity of hypnotherapy for the dates 8/31/05 through 9/13/05.

## **DETERMINATION / DECISION**

The Reviewer agrees with the determination of the insurance carrier.

## **RATIONALE/BASIS FOR THE DECISION**

Based on the *Official Disability Guidelines* and the *Texas Guidelines for Quality Assurance and Practice Parameters*, hypnotherapy-90880 is not considered reasonable or medically necessary for this type of injury. This is a physical injury with physical limitations; normal treatment targets the repair of the injured tissue. Hypnotherapy does not address the physical damage to the injured tissue nor does it increase the range of motion, strength, and stamina needed to return the patient back to a pre-accident status. This should not be included in the treatment plan to lower the outcome assessment scores. Therefore, the service in dispute is not reasonable or medically necessary based on the above-mentioned criteria.

## Screening Criteria

### 1. Specific:

- Texas Guidelines for Quality Assurance and Practice Parameters
- Official Disability Guidelines

### 2. General:

In making his determination, the Reviewer had reviewed medically acceptable screening criteria relevant to the case, which may include but is not limited to any of the following: Evidence Based Medicine Guidelines (Helsinki, Finland); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Texas Chiropractic Association: Texas Guidelines to Quality Assurance (Austin Texas); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Mercy Center Guidelines of Quality Assurance; any and all guidelines issued by DWC or other State of Texas Agencies; standards contained in Medicare Coverage Database; ACOEM Guidelines; peer-reviewed literate and scientific studies that meet nationally recognized standards; standard references compendia; and findings; studies conducted under the auspices of federal government agencies and research institutes; the findings of any national board recognized by the National Institutes of Health; peer reviewed abstracts submitted for presentation at major medical associates meetings; any other recognized authorities and systems of evaluation that are relevant.

### CERTIFICATION BY OFFICER

Clear Resolutions has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Clear Resolutions has made no determinations regarding benefits available under the injured employee's policy.

As an officer of Clear Resolutions Inc., I certify that there is no known conflict between the Reviewer, Clear Resolutions and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Clear Resolutions is forwarding by mail or facsimile, a copy of this finding to the DWC.

Sincerely,  
Clear Resolutions Inc.



Chris Crow  
President & Chief Resolutions Officer

### 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.

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

**I hereby certify, in accordance with DWC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent DWC via facsimile, U.S. Postal Service or both on this 27<sup>th</sup> day of October, 2006.**

**Name and Signature of Clear Resolutions Inc. Representative:**

Sincerely,  
Clear Resolutions Inc.

Chris Crow  
President & Chief Resolutions Officer