



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	
Requestor's Name and Address: Texas Health 5445 La Sierra Dr. #204 Dallas, TX 75231	MDR Tracking No.: M5-06-2009-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Travelers Property & Casualty Box 05	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: Per Requestor's Table of Disputed Services "Services were medically necessary."

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: Carrier states that they "sustain the denial of the claim based on the RME's of 07/14/05 and 03/14/06. Per RME's, ongoing treatment is not required."

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)
08/10/05 – 10/18/05	97545-WH-CA, 97546-WH-CA	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00

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.

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 09/11/06, 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 90801 billed on date of service of 08/02/05 was denied with denial code "TXB7/W1 (Work comp state fee schedule adjustment. Procedure code billed requires pre-authorization. If pre-auth was received reimbursement is made in accordance with the Texas Work Comp Med Fee Guidelines). CPT code 90801 does not require preauthorization unless it is a repeat, per Rule 134.600 (h) (4). Respondent submitted proof that an initial interview was billed and paid for date of service 05/31/05. Therefore CPT Code 90801 billed on 08/02/05 is a repeat procedure and does require preauthorization. Requestor did not submit proof of request for preauthorization, therefore, 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 FINDING & 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 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

11/15/06

Authorized Signature

Typed Name

Date of 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.

MEDICAL REVIEW OF TEXAS

[IRO #5259]

10817 W. Hwy. 71
Phone: 512-288-3300

Austin, Texas 78735
FAX: 512-288-3356

NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISED 10/25/06

TDI-WC Case Number:	
MDR Tracking Number:	M5-06-2009-01
Name of Patient:	
Name of URA/Payer:	Texas Health
Name of Provider: (ER, Hospital, or Other Facility)	Texas Health
Name of Physician: (Treating or Requesting)	Anthony Esquibel, DC

October 16, 2006

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on the Division of Workers' Compensation Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Division of Workers' Compensation

REVISED 10/25/06

DOCUMENTS REVIEWED

Notification of IRO Assignment
Medical Dispute Resolution Request/Response
EOBs St. Paul Travelers
RME Reports, Donald Mauldin, MD
Medical Reports and Appeals, Bradley Eames, DO
Behavioral Medicine Reports, Claudia Rameriz, MA, LPC, Tracey Duran, MS, LPC, LMFT
Physical Therapy, Work Hardening Reports and Progress Notes, Mark Dodson, PT
Group Therapy Reports, Monica Peralta, Ellie Tafal, Erica Penick, Phil Bohart, MA, LPC, CRC
Chronic Pain Management Group Notes, Nichole Mangum, PhD, Jeanne Selby, PhD, Hope Valadez
Physical Medicine Reports, Sherine Boyd Reno, MD
Initial Provider Reports, Concentra, Martha Walkup, DO
Designated Doctor Reports, Martin Jones, MD
RME Reports, Benjamin Cunningham, MD
Chiropractic Peer Review, Robert Hoffman, DC, FIAMA

CLINICAL HISTORY

Available information suggests that this patient reports a work related injury to her neck and left thumb on ___ as a result of a fall. She was seen initially at Concentra and found with sprain of the left thumb and cervicothoracic spine. The patient was placed on light duty and physical therapy with Concentra through April of 2005. Some symptom magnification behavior is noted at this time. In February of 2005 the patient begins treatment with a chiropractor, Dr. Escovel, but no reports of this are available for review. She was subsequently seen by several physicians including Bradley Eams, DO, and Sherine Reno, MD, who found cervical facet syndrome, possible cervical disc disease, tenosynovitis of the wrist and hand, myofascial pain and untreated hypertension. X-rays and electrodiagnostic studies are found essentially unremarkable. MRI reports suggest multiple cervical disc protrusions and early multilevel foraminal stenosis secondary to degenerative changes. MRI of the thumb suggests small fluid collection suggestive of acute trauma. The patient receives multiple pain medications and is recommended for work hardening and chronic pain management programs. Multiple behavioral health and physical therapy assessments were obtained. The patient was seen by a Dr. Cunningham who felt that she would benefit from epidural steroid injections but the patient apparently rejects this treatment. The patient receives designated doctor evaluation with Martin Jones, MD, on April 6, 2005, suggesting that the patient had not yet achieved MMI but suggested that this should have been reached by June 6, 2005. Orthopedic RME is performed July 14, 2005 by Donald Mauldin, MD, who indicates no evidence of major structural injury. Multiple Wadell findings are found consistent with symptom magnification.

REQUESTED SERVICE(S)

Determine medical necessity for requested Work Hardening Program (97545-WH-CA) and Work Hardening each additional hour (97546-WH-CA) for the period in dispute (08/10/05 to 10/18/05).

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

Available records **do not support medical necessity** for an ongoing Work Hardening program and additional hours of this program as recommended by treating doctor and consulting specialty physicians (08/10/05 – 10/18/05). Essentially no documentation is provided from treating doctor, Anthony Esquibel, DC, concerning plan of treatment and rationale for treatment continuation of this nature. Multiple behavioral health evaluations do not appear to address patient's refusal of recommended treatment interventions and symptom magnification behavior which would question her candidacy for these programs.

1. TWCC MFG (TDI) guidelines for Work Hardening and Work Conditioning Programs; (Medicine GR);
2. CARF, Commission on Accreditation of Rehabilitation Facilities, 1990 Standards Manual.
3. Schonstein E, Kenny DT, Keating J, Koes BW. Work conditioning, work hardening and functional restoration (Cochrane Review).

In: *The Cochrane Library*, Issue 2, 2004. Chichester, UK: John Wiley & Sons, Ltd.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials.

No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned individual. These opinions rendered do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.

Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that I have no known conflicts of interest between the provider 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 IRO.

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.

Chief Clerk of Proceedings
Division of Workers' Compensation
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

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

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell