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

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor=s Name and Address:	MDR Tracking No.: M5-06-2062-01 Previous Tracking No.: M5-05-0364-01
Pride P.O. Box 35546 Dallas, Texas 75235	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
AMERICAN CASUALTY CO OF READING, BOX 47	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary states, "We seek full reimbursement for the outstanding balance of $2,314.30 along with the interest accrued according to Rule 134.803."

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 states, "Provider is requesting reimbursement for services performed in which it treated these disputed body parts. Because these body parts are not part of the compensable injury, any treatment for these areas cannot be reasonable and necessary for treatment of the compensable injury."

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. CMS-1500's
3. EOB's

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)
5-13-03 – 6-12-03	97110 ($35.00 x 22 units)	☒ Yes ☐ No	$770.00
5-13-03 – 6-12-03	97530 ($35.00 x 18 units)	☒ Yes ☐ No	$630.00
8-14-03, 8-15-03	99213 ($66.19 x 2 DOS)	☒ Yes ☐ No	$132.38
8-14-03	90801	☒ Yes ☐ No	$190.88
8-14-03	97750-FC ($36.94 x 4 units per CMS 1500)	☒ Yes ☐ No	$147.76
	Total Due		$1,871.02

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. Per Rule 134.202(c)(1) the amount due the Requestor for the items denied for medical necessity is $1,871.02.

Date of service 04-03-03 per Rule 133.308(e)(1) was not timely filed and is ineligible for review.

Some services were also denied as "R-treatment unrelated to the original compensable injury." The DWC 21, dated 8-21-03, submitted by the Respondent, states, "The carrier disputes the extent of injury in that the carrier contends that the alleged injury for stress and depression do not flow from or relate to the compensable injury of Claimant's stress and depression is due to an ordinary disease of life to which the general public is exposed outside of employment. Further, claimant's stress and depression is not part of or related to the compensable injury of Therefore, carrier denies compensability, disability and medical pertaining to the stress and depression." The DWC 21 filed by the Respondent does not pertain to the dispute as the Requestor billed with Diagnosis Code 728.9 which was not mentioned in the Respondent's DWC 21's. There are no compensability issues.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 134.1, 134.202 and 134.201 titled (Medical Fee Guideline for Medical Treatments and Services Provided Under the TX Worker's Compensation Act) effective April 1, 1996
1996 MFG Medicine Ground Rule (I)(A)(9)(b) and (C)(1)(m)
1996 MFG, Evaluation and Management Ground Rule (IV)(C)(2), 134.202(c)(1)
Texas Labor Code Sec.§ 413.011(a-d), 413.031

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 carrier must refund the amount of the IRO fee ($650.00) to the Requestor within 30 days of receipt of this order. The Division has determined that the Requestor is entitled to additional reimbursement in the amount of $1,871.02. 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:

	Medical Dispute Officer	01-22-07
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.

INDEPENDENT REVIEW INCORPORATED

December 19, 2006

Re: **MDR #: M5 06 2062 01** **Injured Employee:**
DWC #: **DOI:**
IRO Cert. #: 5055

TRANSMITTED VIA FAX TO:
TDI, Division of Workers' Compensation
Medical Dispute Resolution
Fax: (512) 804-4868

RESPONDENT: **Gallagher Bassett**

TREATING DOCTOR: **Tom Mayer, MD**

In accordance with the requirement for DWC to randomly assign cases to IROs, DWC assigned this case to IRI for an independent review. IRI has performed an independent review of the medical records to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the office manager of Independent Review, Inc. and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him 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 Independent Review Organization. Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is a board certified in neurology and is currently listed on the DWC Approved Doctor List.

This decision by Independent Review, Inc. is deemed to be a DWC decision and order.

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.

Sincerely,

Jeff Cunningham, DC
Office Manager

P.O. Box 855
Sulphur Springs, TX 75483
903.488.2329 * 903.642.0064 (fax)

INDEPENDENT REVIEW INCORPORATED

REVIEWER'S REPORT
M5 06 2062 01

MEDICAL INFORMATION REVIEWED:

1 Carrier's records
2 Records of the treating provider
3 Records from ancillary providers.

BRIEF CLINICAL HISTORY:
The patient is a 36-year-old woman who has a date of injury of The cause of this was allegedly "repetitive stress" sustained while working and involved her right hand, wrist, and index finger. A diagnosis of tenosynovitis was made. She was treated by a variety of physicians and therapists for chronic pain, and at a point in time was referred for "psychosocial assessment" because of anxiety and depression associated with difficulty sleeping. The claimant was also evaluated and treated for her chronic pain in the "PRIDE" program in 2004. There have been a number of denials of therapy, which have been contested and overturned in this case. These were for services actually rendered after the contested dates of service now being questioned. The services have actually at times been "precertified," although specific authorization for the items in dispute were not found in records reviewed.

DISPUTED SERVICES:
The current items in dispute are for date of service 05/13/03 through 08/15/03 with CPT codes 97750 FC physical performance test, 99213 office visit, 97110 therapeutic exercises, 97530 therapeutic activities, and 90801 physical evaluation. These have been denied as being medically unnecessary after peer review.

DECISION:

I DISAGREE WITH THE DETERMINATION OF THE INSURANCE CARRIER ON THIS CASE.

RATIONALE OR BASIS FOR DECISION:
After reviewing the medical records, it is this reviewer's opinion that the questioned services should be certified as medically necessary. The rationale for this decision is the fact that subsequent treatments were considered medically necessary, and the patient was clearly symptomatic throughout the period in question. The evaluation and treatments rendered were reasonable and appropriate.

SCREENING CRITERIA/TREATMENT GUIDELINES/ PUBLICATIONS UTILIZED:
ACOEM Guidelines were considered in this review, but the services questioned are not fully covered by this or other guidelines for Workers' Compensation. In particular, the services were rendered when the client had not yet reached maximum medical improvement.