



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: Gabriel Gutierrez, D.C. P O BOX 229 Katy, Texas 77229-0229	MDR Tracking No.: M5-07-0158-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Rep Box # 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: "It is my position that carrier's, adjustor's and/or carrier's agents (auditing company/peer reviewer(s) denial of payment for reasonable and medically necessary treatment provided to the injured employee is not because of the lack of medical necessity but rather it is because of the carrier's, the adjuster's and the carrier's agents blanket denial policy and willful and an intentional non-compliance the Act, Rules, appropriate fee and treatment guidelines."

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: "This is a fee dispute involving retrospective medical necessity. The carrier disputes that the provider has shown that the treatment underlying the charges was medically reasonable and necessary. Further, the carrier challenges whether the charges are consistent with applicable fee guidelines. The carrier asserts that is has paid according to applicable fee guidelines. "

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)
11-16-05 to 12-10-05	97545-WH-CA (1 unit @ \$64.00 X 2 units X 10 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,280.00
11-16-05 to 12-10-05	97546-WH-CA (1 unit @ \$64.00 X 6 units X 10 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$3,840.00
11-04-05	97750-FC	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$464.10
TOTAL DUE			\$5,584.10

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 10-26-2006, 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 for date of service 11-04-05 was denied by the Respondent with denial code "39" (services denied at the time authorization/pre-certification was requested). The Requestor did not submit medical documentation for review, therefore, Medical Dispute Resolution cannot determine if this service was for an initial psychiatric diagnostic interview or for a repeat interview. Per Rule 134.600(h)(4) a repeat interview requires preauthorization. No reimbursement recommended.

CPT code 97545-WH-CA billed for dates of service 12-02-05 through 01-12-06 were denied by the Respondent with denial codes "15" (payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider) and "W4" (no additional reimbursement allowed after review of appeal/reconsideration). The Respondent has not made a payment. Per Rule 134.600(h)(9) CARF accredited programs do not require preauthorization. Reimbursement per Rule 134.202(e)(5)(A)(i) and 134.202(e)(5)(C)(i)(ii) is recommended in the amount listed below.

1 unit @ \$64.00 X 2 units = \$128.00 X 20 DOS = **\$2,560.00**

CPT code 97546-WH-CA billed for dates of service 12-02-05 through 01-12-06 were denied by the Respondent with denial codes "15" (payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider) and "W4" (no additional reimbursement allowed after review of appeal/reconsideration). The Respondent has not made a payment. Per Rule 134.600(h)(9) CARF accredited programs do not require preauthorization. Reimbursement per Rule 134.202(e)(5)(A)(i) and 134.202(e)(5)(C)(i)(ii) is recommended in the amount listed below.

1 unit @ \$64.00 X 6 units = \$384.00 X 20 DOS = **\$7,680.00**

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.1, 134.202(d)(2), 134.202(e)(5)(A)(i) and 134.202(e)(5)(C)(i)(ii)
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 \$15,824.10. 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.

Findings and Decision by:

02-01-2007

Authorized Signature

Typed Name

Date of Findings and Decision

Order by:

02-01-2007

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.

December 4, 2006
Amended December 6, 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: M5-07-0158-01
RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 10.26.06.
- Faxed request for provider records made on 10.26.06.
- The case was assigned to a reviewer on 11.20.06.
- The reviewer rendered a determination on 12.4.06.
- The Notice of Determination was sent on 12.4.06.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of Work Hardening-97545-WHCA/ 97546-WHCA and FCE- 97750-FC
The dates listed in dispute are 11.4.05-12.1.05.

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 services (Work Hardening-97545-WHCA/ 97546-WHCA and FCE- 97750-FC) that occurred between 11.4.05-12.01.05.

Summary of Clinical History

The claimant sustained a work related injury on _____. The claimant has received various forms of care, consultations and had right knee surgery on 6.17.05.

Clinical Rationale

The claimant has an injury that precluded her from regular work activities; as a result, periodic functional capacity studies are routine and reasonable. Functional capacity studies must be used as a compass to determine improvement, outcome assessment and necessity for services and therapy. On functional testing for this particular patient, it is clear that the claimant had functional limitations. Documentation provided reveals that there are clear mental and psychological symptoms that correlation with the accident they were in as well as circumstances that surround the injury and not being able to work. The claimant is post-surgical and failed to substantially improve with other forms of acute rehabilitation and care. The claimant meets virtually every criteria that is necessary in order to support tertiary rehabilitative services such as work hardening. It is clear that there was a need for more aggressive, multi-disciplinary therapy to address the claimants functional, psychological, vocational and physical needs.

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
- *Standards as set forth by CARF*

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 4th day of December, 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.