



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: James Tanner, D.C. 5350 S. Staples Suite # 210 Corpus Christi, Texas 78411	MDR Tracking No.: M5-07-0400-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Bankers Standard Insurance Company Rep Box # 15	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: Per the Table of Disputed Services "Treatment was med. 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: The Respondent did not submit a position summary to MDR.

Principle Documentation: The Respondent did not submit a response to MDR.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
02-27-2006	97750-FC (1 unit @ \$35.51 X 12 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$426.12
02-27-2006	99244	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$205.84
TOTAL DUE			\$631.96

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.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 134.202
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 \$631.96. 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 Order by:

03-20-07

Authorized Signature

Typed Name

Date of Findings and 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.

March 1, 2007
Amended: March 5, 2007

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: M5-07-0400-01
RE: Independent review for _____

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

- Parker Healthcare Management received notification of independent review on 1.12.07.
- Faxed request for provider records made on 1.12.07.
- TDI-DWC issued an Order for records on 1.29.07.
- The case was assigned to a reviewer on 2.9.07.
- The reviewer rendered a determination on 2.28.07.
- The Notice of Determination was sent on 3.1.07.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of CPT code 97750-FC and 99244-office consult. Date of service in dispute is 2.27.06.

Determination

PHMO, Inc. has performed an independent review of the disputed 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 both of the disputed service(s).

Summary of Clinical History

The patient fell while exiting a golf cart. He was employed with _____ as a security guard. He fractured his left wrist. The styloid process apparently did not unionize. This was surgically remedied. He was also treated for lower back issues.

Clinical Rationale

From the material in my possession, it appears Dr. Echavarria referred the patient to an alternate provider (Dr. Tanner) to perform the FCE. The FCE is an exhaustive series of measures and tests used to discover information that would otherwise be unknown to the provider. The clinical notes indicate this evaluation served an instrumental role in determining RTW (return-to-work) capabilities for the patient. This evaluation was relied upon in the provider's determination to release the patient back to work with some restrictions. Additionally, I do not have any information whatsoever from the carrier. Dr. Tanner seems to believe that a retrospective utilization review was not performed for this. Given the nature of the FCE and its role in resolving RTW issues, and in the absence of any controvert medical evidence, medical necessity is clearly established.

The consultation associated with the FCE was billed with a fairly robust CPT code. However, the patient has been off of work for a full year at this point. Transition back to a restricted work environment can realistically cause a lot of questions to come to the service. It is not unrealistic for a provider to offer the level of service implied with this CPT code to a patient faced with this change. An FCE is also a very involved test to explain to a patient. CPT also does not include a consultation with use of the 97750 code. Therefore, a separate service is appropriate to discuss the test results with the patient. Consequently, medical necessity for the consultation is established.

Clinical Criteria, Utilization Guidelines or other material referenced

CPT Guide, published by the AMA

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 1st day of March, 2007. 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.