



Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE 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: David V. Dent, DO PA P.O. Box 362 Palestine, Texas 75802	MDR Tracking No.: M5-07-0694-01 Previous Tracking No.: M4-07-0137-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: INSURANCE CO OF THE STATE OF PA BOX 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position Summary (Table of Disputed Services): "FCE was medically necessary to discharge patient to safe work level. FCWE for this injury per Rule 134.202 max of 3 FCE's allowed per injury shall be billed and reimburse. [sic]"

Principle Documentation:

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

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position Summary: "Provider cannot establish that the FCE performed on November 22, 2005 is healthcare reasonably required for Claimant's work-related injury."

Principle Documentation:

1. DWC-60/Table of Disputed Services/Position Summary
2. Peer review

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)
11-22-05	97750-FC	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
	Total Due		\$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. No reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

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

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 IRO and is not entitled to reimbursement for the services involved in this dispute.

Findings and Decision by:

4-12-07

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.

Notice of independent Review Decision

SENT TO:

Texas Department of Insurance
Health & Workers' Compensation Network Certification and QA
Division (HWCN) MC 103-5A
Via E-mail IRODecisions@tdi.state.tx.us

Injured Employee:

Provider:

DAVID V DENT
ATTN: TAMMY ORR
PO BOX 632
PALESTINE, TX 75802
FAX: 903-723-8252
PHONE: 903-723-7178

Other Provider:

INSURANCE CO OF THE STATE OF PA/ FOL, TX
ATTN: KATIE FOSTER
504 LAVACA, STE 1000
AUSTIN, TX 78701
FAX: 512-867-1733
PHONE: 512-435-2266

March 5, 2007

RE: IRO Case #: M5-07-0694-01

Name: ___

Coverage Type: Workers' Compensation Health Care (Non-network)

Type of Review: retrospective

Medical Review Institute has been certified, certification number 5278, by the Texas Department of Insurance (TDI) as an Independent Review Organization (IRO). TDI has assigned this case to the IRO for independent review in accordance with the Texas Insurance Code, the Texas Labor Code and applicable regulations.

The IRO has performed an independent review of the proposed/rendered care to determine if the adverse determination was appropriate. In the performance of the review, the IRO reviewed the medical records and documentation provided to the IRO by involved parties.

This case was reviewed by a pain management DO. The reviewer 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 (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

As an officer of Medical Review Institute of America I certify that:

1. There is no known conflict between the reviewer, the IRO and/or any officer/ employee of the IRO with any person or entity that is a party to the dispute, and
2. A copy of this IRO decision was sent to all of the parties via U.S. Postal Service or otherwise transmitted in the manner indicated above on 3/6/07.

Right to Appeal

You have the right to appeal the decision by seeking judicial review. The decision of the IRO is binding during the appeal process.

For disputes other than those related to prospective or concurrent review of spinal surgery the appeal must be filed:

- 1) Directly with a district court in Travis County (see Labor Code §413.031(m), and
- 2) Within thirty (30) days after the date on which the decision is received by the appealing party.

For disputes related to prospective or concurrent review of spinal surgery, you may appeal the IRO decision by requesting a Contested Case Hearing (CCH). A request for a CCH must be in writing and received by the Division of the Workers' Compensation, Division Chief Clerk, within ten (10) days of your receipt of this decision.

Sincerely,

Case Analyst: Laura S 520
Case Fulfillment Specialist

DATE OF REVIEW: March 6, 2007
IRO Case #: M5-07-0694-01

Description of the services in dispute:

Retrospective review – Functional Capacity Evaluation (#97750-FC).

A description of the qualifications for each physician or other health care provider who reviewed the decision

The physician providing this review is board certified in Anesthesiology and is a doctor of Osteopathy. The reviewer is currently an attending physician at a major medical center providing anesthesia and pain management services. The reviewer has participated in undergraduate and graduate research. The reviewer has been in active practice since 1988.

Review Outcome

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld.

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Medical necessity does not exist for the Item in Dispute: Retrospective review – Functional Capacity Evaluation (#97750-FC).

Information provided to the IRO for review

Records Received From the State:

Notification of IRO assignment, 2/12/07

Notice of receipt of request for Medical Dispute Resolution, 8/29/06

Medical Dispute Resolution Request/Response x 2

Table of Disputed Services

Provider Bill Audit report, 9/13/06

Records Received From the Respondent:

Letter from Scott D. Bouton to Ms. Sterken, 2/20/07

Letter from Scott D. Bouton to Ms. Rich, 9/25/06

Provider Bill and Audit Report, 9/13/06

Provider Bill and Audit Report, 12/22/05

Provider Bill and Audit Report, 3/2/06

Records Received From the Requestor:

Retrospective Medical Review, 6/2/05

WC Office Visit note, 11/15/05

Functional Capacity Evaluation, 11/22/05

Patient clinical history [summary]

This is a 71-year-old male patient with a date of injury on _____. The patient had a cervical and lumbar injury, with EMG (electromyography) indication of radiculopathy of both. He had 25 PT (physical therapy) sessions, followed by an FCE (functional capacity evaluation) in 10/04, which indicated he was capable of medium duty. He worked as a grounds keeper (maintenance man). He tested at a medium capacity, and his job reportedly requires an unrestricted capacity. He then had 15 work conditioning sessions. He followed this with ESIs (epidural steroid injections). He continued to complain of pain, and had another FCE in 11/05, which is the service in question. This showed undetermined effort, but noted he tested at medium capacity again. It does not appear that he returned to work during any of this time.

Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision.

This patient had appropriate care for his situation. He then had an FCE in 10/04, which showed medium capacity. He could have and should have returned to work in this capacity, even if it involved restrictions, but there is no indication he did. Instead, he had 15 work conditioning sessions, meant to return him to work, and still that did not happen. A year later, another FCE is not warranted, as the patient did not attempt to return to work, nor did he do anything to notably change his condition, other than an ESI, which has questionable efficacy a year and a half post injury.

A description and the source of the screening criteria or other clinical basis used to make the decision:

Common practice among pain and osteopathic physicians

ACOEM guidelines copyright 2004 pg 137-138

Bonica's Management of Pain third edition copyright 2000

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