

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## Retrospective Medical Necessity Dispute

### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> ( ) HCP (X) IE ( ) IC	<b>Response Timely Filed?</b> ( ) Yes (X) No
Requestor's Name and Address	MDR Tracking No.: <b>M5-05-1462-01</b>
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address LM Insurance Corporation Box 28	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

### PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
01-20-04	01-20-04	97140 and 97110	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
02-17-04	07-19-04	Co-payments	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
01-26-04	01-26-04	98940	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
02-02-04	02-02-04	98941	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
02-12-04	02-12-04	98941	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

### PART III: 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 Commission Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Medical Review Division 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 **prevailed** on the **majority** of disputed medical necessity issues. Reimbursement from the carrier for the medical necessity issues equals **\$707.65**.

Ombudsman Assistance: An unrepresented injured worker may be assisted by a Commission Ombudsman at the State Office of Administrative Hearings. To request Ombudsman assistance please call 512.804.4176 or 1.800.372.7713 ext 4176.

Asistencia por parte del Ombudsman: Un trabajador lesionado puede obtener asistencia por parte de un Ombudsman de la Comisión en un procedimiento ante la Oficina Estatal de Audiencias Administrativas (sigla SOAH). Para pedir asistencia de un Ombudsman, favor de llamar a 512.804.4176 o al 1.800.372.7713.

### PART IV: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to reimbursement in the amount of \$707.65. The Division hereby **ORDERS** the insurance carrier to remit this amount in dispute consistent with the applicable fee guidelines, plus all accrued interest due at the time of payment, to the Requestor within 20-days of receipt of this Order.

Findings and Decision and Order By:

\_\_\_\_\_  
Authorized Signature

07-08-05

\_\_\_\_\_  
Date of Order

**PART V: INSURANCE CARRIER DELIVERY CERTIFICATION**

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: \_\_\_\_\_ Date: \_\_\_\_\_

**PART VI: YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on \_\_\_\_\_. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**

**Parker Healthcare Management Organization, Inc.**

3719 N. Beltline Road, Irving, TX 75038  
972.906.0603 972.255.9712 (fax)  
Certificate # 5301

July 6, 2005

**ATTN: Program Administrator**  
**Texas Workers Compensation Commission**  
Medical Dispute Resolution, MS-48  
7551 Metro Center Drive, Suite 100  
Austin, TX 78744  
Delivered by fax: 512.804.4868

## Notice of Determination

MDR TRACKING NUMBER: M5-05-1462-01  
RE: Independent review for \_\_\_\_

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

- Parker Healthcare Management received notification of independent review on 5.25.05.
- Faxed request for provider records made on 5.26.05.
- The case was assigned to a reviewer on 6.13.05.
- The reviewer rendered a determination on 7.1.05.
- The Notice of Determination was sent on 7.6.05.

The findings of the independent review are as follows:

### Questions for Review

The services currently in dispute are 97140 (Manual Therapy), 97110 (Therapeutic exercises), 98940 (Chiropractic manipulative treatment), 98941 (Chiropractic treatment 3-4) and co payments denied by the carrier as unnecessary treatment based upon a peer review. The dates of service that are in question are 1.20.04 through the dates of 7.19.04 and consists of what seems to be approximately 32 visits.

### 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 the denial for the chiropractic adjustments (CPT 98940, 98941) on 1.26.04, 2.2.04 and 2.12.04 should be **upheld**. The chiropractic adjustments **were not** medically necessary.

The denial for all other services are **overturned**. The remaining services **were** medically necessary.

### Summary of Clinical History

Ms. \_\_\_\_ sustained a work related injury that occurred on \_\_\_\_, while employed with

### Clinical Rationale

The patient had a documented exacerbation to her ankle. A review of the documentation revealed that RSD might have been involved. A substantial 7% Impairment Rating was assigned by the Designated Doctor. Healed sprains and other injuries are subject to exacerbation. The treating doctor did note the presence of symptoms during his evaluation following the exacerbation showing medical necessity for treatment. The appropriate therapy was prescribed and rendered, resulting in a favorable outcome for the patient. In her cover letter, the patient describes paying for the care out of her own pocket. This seems to indicate that the patient felt strongly about her perceived need for the care.

The chiropractic adjustments to "stabilize" do not appear to be related to her ankle exacerbation. Dr. J. Frahm expressly states in her letter (4.14.2005) that the adjustments are to the spine, and not the ankle. Reduction of mechanical fixations (Subluxations) to the spine do not promote healing to strained tissue in the ankle. Dr. Farhm's rationale is unsupported by conventional literature regarding care for an ankle sprain.

## 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

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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 the Texas Workers Compensation Commission. In accordance with the act and the rules, the review is listed on the TWCC'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 any of the providers or other parties associated with this case. 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 REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Tex. Admin. Code § 148.3). This Decision is deemed received by you 5 (five) days after it was mailed and the first working day after the date this Decision was placed in the carrier representative's box (28 Tex. Admin. Code § 102.5 (d)). A request for hearing should be sent to: Chief Clerk of Proceeding/Appeals , P.O. Box 17787, Austin, Texas 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request. The party appealing the Division's Decision shall deliver a copy of this written request for a hearing to the opposing party involved in the dispute.

I hereby verify that a copy of this Findings and Decision was faxed to TWCC, Medical Dispute Resolution department applicable to Commission Rule 102.5 this 6<sup>th</sup> day of July, 2005. The TWCC Medical Dispute Resolution department will forward the determination to all parties involved in the case including the requestor, respondent and the injured worker. Per Commission Rule 102.5(d), the date received is deemed to be 5 (five) days from the date mailed and the first working day after the date this Decision was placed in the carrier representative's box.

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Meredith Thomas  
Administrator  
Parker Healthcare Management Organization, Inc.