

MDR Tracking #M5-05-1895-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 2-25-05.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The office visit, electrical stimulation, mechanical traction and chiropractic manipulative treatment spinal were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services. The amount to be reimbursed for medical necessity issues is \$167.34.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees totaling \$167.34 for 10-27-04 through 11-1-04 outlined above as follows:

- In accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c);
- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this Order.

This Order is hereby issued this day of 5th May, 2005.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO decision

Parker Healthcare Management Organization, Inc.

3719 North Belt Line Road, Irving, TX 75038
972.906.0603 972.255.9712 (fax)

April 22, 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: M5-05-1895-01
RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 3.31.05.
- Fax request for provider records made on 3.31.05.
- The case was assigned to a reviewer on 4.12.05.
- The reviewer rendered a determination on 4.19.05.
- The Notice of Determination was sent on 4.22.05.

The findings of the independent review are as follows:

Summary of Clinical History

The claimant was injured as a result of an on the job injury that caused right shoulder pain and pathology, while trying to apprehend a suspect at her place of employment. Due to her injury, the patient has received various types of therapy, diagnostics and consultations.

Questions for Review

The codes in dispute are: (99212) Occupational visit, (G0283) Electrical Stimulation, (97012) Mechanical traction and (98940) Chiropractic manipulative procedures. All being denied by the carrier as unnecessary with a peer review, (EOB code "V"). Dates of Service in dispute are 10.27.04-11.01.04.

Determination

After review of all the medical records provided, it is determined to **overturn the denial** for services performed on 10.27.04-11.1.04. All disputed codes for DOS 10.27.04-11.1.04 were medically necessary and reasonable.

Clinical Rationale

The patient has a documented acute exacerbation of a condition that was treated successfully. The patient had a flare up and received care that successfully treated that flare up. The patient is post surgical so these scenarios are to be expected and the treatment adhered to the labor codes description of necessity. The peer review dated 9.27.04 that was used to deny treatment according to the EOB actually reveals that further therapy "would be necessary to manage acute exacerbations related to work activities not resolved with home exercise; and should not exceed 1 to 2 office visits of manual therapy with one modality as needed per episodic event to restore claimant to the previous MMI Status." On, 10.27.04 the patient experienced exacerbations of pain with restricted ROM and muscle spasms. This was the first time the patient was treated for exacerbation of pain since being discharged from care 8.23.04. The rendering doctor did exactly what the peer review recommended and his peer review report should not be used to deny care.

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

The reviewer for this case is a doctor of chiropractic peer matched with the provider that rendered the care in dispute. The reviewer is a diplomat of the American Chiropractic Neurology Board, and serves as an Associate Professor with the Carrick Institute. 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.

In accordance with TWCC Rule 102.4 (h), a copy of this decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 22nd day of April ,2005.

If our organization can be of any further assistance, please feel free to contact me.

Sincerely,

Meredith Thomas
Administrator

CC:

Allen Glen Haywood, DC
Attn: Tammy Orr
Fax: 903.723.8252

TML-IRP/F.O.L.
Attn: Katie Foster
Fax: 512.867.1733

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