



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

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION
Amended 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: Neuromuscular Institute of Texas – PA 9502 Computer Drive Suite 100 San Antonio, Texas 78229	MDR Tracking No.: M5-05-1951-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Box 28	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60, explanations of benefits and CMS 1500s
POSITION SUMMARY: From table of disputed services: "Treatment based on injured worker's need and the doctor's professional judgment. Treatment performed to alleviate or minimize effects of the injury and to promote recovery."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60
POSITION SUMMARY: None submitted by Respondent

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
03-17-04 to 04-05-04	97110, 97140, 97035, 99213 and A9300	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,178.44
04-12-04 to 08-06-04	97110, 97140, 97035, G0283, 99213 and A9300	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$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 **majority** of disputed medical necessity issues.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by Medical Dispute Resolution.

On 10-10-05, the Medical Review Division 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 99080-73 dates of service 07-14-04 and 08-06-04 denied with denial code "V" (unnecessary medical treatment). Per Rule 129.5 the TWCC-73 is a required report which is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. Reimbursement is recommended in the amount of **\$30.00 (\$15.00 X 2 DOS)**. A Compliance and Practices referral will be made as the carrier is in violation of Rule 129.5.

This AMENDED FINDINGS AND DECISION supersedes all previous Decisions rendered in this Medical Payment Dispute involving the above requestor and respondent.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and Rules 129.5, 134.202(c)(1)

PART VII: DIVISION AMENDED DECISION 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 additional reimbursement in the amount of \$1,208.44. In addition, the Division finds that the requestor was not the prevailing party and is not entitled to a refund of the IRO fee. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30 days of receipt of this Amended Order.

Amended Order by:

11-08-05

Authorized Signature

Date of Amended 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.

Parker Healthcare Management Organization, Inc.

4030 N. Beltline Road, Irving, TX 75038

972.906.0603 972.255.9712 (fax)

Certificate # 5301

September 26, 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: M5-05-1951-01

RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 8.9.05.
- Faxed request for provider records made on 8.9.05.
- TWCC issued an Order for Documents from the respondent on 8.22.05.
- The case was assigned to a reviewer on 9.13.05.
- The reviewer rendered a determination on 9.23.05.
- The Notice of Determination was sent on 9.26.05.

The findings of the independent review are as follows:

Questions for Review

The therapy in question consists of manual therapy techniques (97140), therapeutic exercise (97110), Ultrasound (97035), electrical stimulation (G0283), office visits (99213) and exercise equipment (A9300).

The dates of service in question are from 3.17.2004 through the date of 8.6.2004. The denial is based upon a lack of medical necessity.

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

all of the requested service(s) (99213, 97140, 97110, 97035, G0283 and A9300) performed on each date of service up until 4.7.2004.

Specifically, these dates include: 3.17.2004, 3.19.2004, 3.24.2004, 3.26.2004, 3.29.2004 and 4.5.2004.

The PHMO, Inc. physician reviewer has also determined to **uphold the denial** on all of the requested service(s) that occurred on or after 4.8.2004.

Summary of Clinical History

Ms. ___ sustained a work related job injury on ____. She has since been suffering from work related complaints in regards to bilateral carpal tunnel syndrome, bilateral lateral epicondylitis and right sided shoulder derangement. The patient had right shoulder surgery on 1.7.2004, which consisted of a Mumford procedure and claviclectomy. There is also documentation of a carpal tunnel release in 2000 and 2001.

Clinical Rationale

In regards to the post surgical rehabilitation of the right shoulder, there was initial weakness and range of motion loss to the injured shoulder. The initial evaluation demonstrated this. Follow up evaluations demonstrate continued problems, but improvement with strength and range of motion. The evaluation on 4.7.2004 shows significant improvements with shoulder strength and range of motion. The range here in flexion went from 105 degrees to 120 degrees in regards to flexion. Abduction improved from 85 to 122 degrees. Strength is documented in all planes of shoulder movement on this follow up.

However, on 5.17.2004 the patient was again evaluated, but this time the strength improvement was no different than the previous visit. The range of motion had changed very minimally, improving in some areas and not in others. It appears that there was a significant amount of improvement from rehabilitative and conservative care between the dates of 3.17.2004 and 4.07.2004. In these dates, it appears that all of the listed services were medically adequate including therapeutic exercise, ultrasound, e-stimulation, and office visits. The exercise equipment to my knowledge was for home exercise use and consisted of Thera-bands that the patient did use. The billing of exercise equipment for at home use is supported.

After the evaluation on 4.7.2004, there was little documented improvement demonstrated by the follow up evaluations. It appears that the patient reached maximum therapeutic improvement from the therapy in dispute at that time.

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 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 (other than a spinal surgery prospective 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.

If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision. The address for the Chief Clerk of Proceedings would be: P.O. Box 17787, Austin, Texas, 78744.

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 26th day of September, 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.

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.