

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP () IE () IC	Response Timely Filed? (X) Yes () No
Requestor's Name and Address Work & Accident Clinic 4924 Greenville Avenue Dallas, Texas 75206	MDR Tracking No.: M5-05-2302-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Hartford Underwriters Insurance Box 27	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		
06-23-04	10-20-04	97110, 97112 and 99213	<input checked="" type="checkbox"/> Yes <input 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 **did** prevail on the disputed medical necessity issues. The amount due from the carrier for the medical necessity issues equals **\$13,075.96**.

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 the Medical Review Division.

On 06-01-2005, 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.

Review of CPT code 99213 date of service 06-23-04 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for EOBs for dates of service 06-23-04 through 07-19-04, however, the reconsideration request is for services denied with "F" or "N", the proof of a request for reconsideration does not include a request for an EOB for CPT code 99213 date of service 06-23-04. No reimbursement is recommended.

Review of CPT code 99213 date of service 09-17-04 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for EOBs for dates of service 06-23-04 through 07-19-04, however, the reconsideration request is for services denied as unnecessary medical treatment with peer review, the proof of a request for reconsideration does not include a request for an EOB for CPT code 99213 date of service 09-17-04. No reimbursement is recommended.

CPT code 99213 dates of service 09-03-04 and 09-23-04 denied with denial code "N" (documentation does not justify level of service). The requestor did not submit documentation for review. No reimbursement recommended.

CPT code 99080-73 date of service 10-06-04 denied with denial code "N" (documentation does not justify level of service). The requestor did not submit documentation for review. No reimbursement recommended.

PART IV: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to a refund of the paid IRO fee in the amount of \$460.00. The Division hereby **ORDERS** the insurance carrier to remit this amount and the appropriate amount for the services in dispute totaling \$13,075.96 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 by:

08-09-05

Authorized Signature

Date of Decision

Order by:

08-09-05

Authorized Signature

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 14, 2005

Amended: July 25, 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: M5-05-2302-01

RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 6.7.05 by UPS.
- Faxed request for provider records made on 6.8.05.
- TWCC issued an Order for Records on 6.22.05.
- The case was assigned to a reviewer on 7.01.05.
- The reviewer rendered a determination on 7.11.05.
- The Notice of Determination was sent on 7.14.05.
- TWCC requested amendment of determination, completed on 7.25.05.

The findings of the independent review are as follows:

Questions for Review

The items in dispute are the following: (97110) Therapeutic Exercise, (97112) Neuromuscular re-education, (99213) Office visits, (97140) Manual therapy technique and (97750) Physical performance testing. These are denied with a "V" code which is a denial for medical necessity. The dates in dispute are listed as 6.23.04 thru the dates of 10.20.04.

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 the denied charges.

Summary of Clinical History

Mr. ____ sustained a work related injury on _____. He stated he fell off of a truck as it attempted a sharp corner. He has been diagnosed with right shoulder sprain / strain, right hip strain / sprain, right knee strain / sprain and right elbow strain / sprain.

Clinical Rationale

The physical performance evaluations were done at the appropriate intervals during treatment and were not over-utilized. They were informative and demonstrated that the patient had improved AROM and muscular strength. The studies were objective and informative in updating the patient's care and case. The disputed office visits and therapies appeared to improve the patient's functioning and was provided at reasonable intervals. The documentation provided did reveal a reduction of symptoms and a reduction of objective findings. In light of this, the disputed care is medically necessary.

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 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 14th day of June, 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.