



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

## MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

### Retrospective Medical Necessity and Fee Dispute

#### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address: Humpal Physical Therapy 5026 Deepwood Circle Corpus Christi, Texas 78415	MDR Tracking No.: M5-05-2821-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Insurance Company Box 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

#### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documentation submitted: TWCC-60, letter of medical necessity, explanation of benefits, CMS 1500s, medical documentation. Position summary: Services were medically necessary according to Texas Labor Code 408.021.

#### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documentation submitted: Response to TWCC-60 and explanation of benefits. Position summary: This dispute involves the carrier's payment for date of service 9/1/2004 to 10/7/2004. The requester billed \$1,480.00; Texas Mutual paid \$0.00. The requester believes it is entitled to an additional of \$1,446.19.

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
9-1-04 to 10-7-04	97110 and 97112	<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 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 07-21-05, 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 97002-25-GP dates of service 09-01-04, 09-07-04 and 10-07-04 per Rule 134.202(b) were billed with an invalid modifier (25). No reimbursement is recommended.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. 133.308 and Rule 134.202(b)

**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 services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

09-20-05

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

\_\_\_\_\_  
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.**

**Parker Healthcare Management Organization, Inc.**

4030 N. Beltline Road, Irving, TX 75038  
972.906.0603 972.255.9712 (fax)  
Certificate # 5301

September 7, 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: M5-05-2821-01  
RE: Independent review for \_\_\_\_

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

- Parker Healthcare Management received notification of independent review on 7.21.05.
- Faxed request for provider records made on 7.21.05.
- TWCC requested an Order for Documents to the respondent on 8.3.05.
- The case was assigned to a reviewer on 8.15.05.

- The reviewer rendered a determination on 9.6.05.
- The Notice of Determination was sent on 9.7.05.

The findings of the independent review are as follows:

## Questions for Review

Medical necessity of therapeutic exercises (97110), neuromuscular reeducation (97112); DOS in dispute 9.1.04-10.7.04; FEE denied items were not reviewed

## 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 **uphold the denial** on the requested service(s).

## Summary of Clinical History

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

## Clinical Rationale

It is noted that the patient ultimately had a good outcome, due in no small part to the surgical, medical, and rehabilitation care she received. The duration of the Physical Therapy care this patient received seems excessive and the documentation of this care is not adequate enough to support it.

In the P.T. notes dated 9.1.04 & 9.7.04 the therapist states “*the patient has right knee range of motion that is within normal limits*”; yet the treatment administered for these dates of service include “*therapeutic exercise to increase right knee range of motion*”.

It should also be noted that the professional literature I consulted does not recommend a specific duration of treatment for neuromuscular re-education for this type of patient. These decisions are left up to the clinician’s professional judgment. However, my professional experience is that the 3 months of neuromuscular re-education treatment this patient received is both excessive and not supported by available documentation.

Based on the above information it is my determination to uphold the denial set forth by the URA in the case of Ms. \_\_\_.

## Clinical Criteria, Utilization Guidelines or other material referenced

This conclusion is supported by the reviewers’ clinical experience as a Physical Therapist with over 5 years of experience.

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The reviewer for this case is a Physical Therapist peer matched with the provider that rendered the care in dispute. The reviewer is engaged in the practice of physical therapy 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 7<sup>th</sup> 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.

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Meredith Thomas  
Administrator  
Parker Healthcare Management Organization, Inc.