



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

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address: Julio Fajardo, D.C. 2121 N. Main Street Fort Worth, Texas 76106	MDR Tracking No.: M5-05-2866-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Liberty Mutual Fire Insurance Box 28	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: TWCC-60, explanation of benefits, CMS 1500s
POSITION SUMMARY: Medically necessary post-op rehab

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Carrier submitted TWCC-21 disputing disability

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
02-09-05 to 03-02-05	97140, 97110, 97035, G0283 and 99212-25	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,674.60

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 **prevailed** on the disputed medical necessity issues. The amount due from the carrier for the medical necessity issues equals **\$1,674.60**.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308

PART VII: DIVISION 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 reimbursement in the amount of \$1,674.60. In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of 460.00. 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 Order.

Findings and Decision and Order by:

09-22-05

Authorized Signature

Date of 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 15, 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: M5-05-2866-01
RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 8.3.05.
- Faxed request for provider records made on 8.3.05.
- TWCC issued an Order for Records on 8.17.05.
- The case was assigned to a reviewer on 9.2.05.
- The reviewer rendered a determination on 9.14.05.
- The Notice of Determination was sent on 9.15.05.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of manual therapy technique (97140), therapeutic exercises (97110), ultrasound (97035), electrical stimulation (G0283), and established patient office visits (99212-25) for dates of service 2.9.05 through 3.2.05.

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).

Summary of Clinical History

Ms. ___ is a 55-year-old female custodian who, on ___, was walking downstairs with her hands on the railing when she slipped. Reportedly, her left hand came off the rail but her right hand remained on the rail to catch herself. However, in the process of doing so, she twisted her neck and right shoulder. She was treated initially by an occupational health facility that diagnosed a simple strain and initiated physical therapy.

She soon changed treating doctors to a doctor of chiropractic, who continued with chiropractic care, physical therapy and rehabilitation. MRI of the cervical spine was normal, but an MRI of the right shoulder revealed evidence of tendinosis of the supraspinatous tendon, with no evidence of a tear. Epidural steroid injections and facet medial branch blocks were also attempted.

However, despite attempts at resolution with conservative means, the patient underwent right shoulder arthroscopy with an acromioplasty, A/C joint resection, distal clavicle excision, and rotator cuff debridement on 5.19.04. This procedure was then followed by post-operative physical therapy and rehabilitation. When the patient's right shoulder pain persisted, despite the surgical procedure, an A/C joint and subacromial injection was then attempted on 8.17.04. On 2.1.05, she underwent manipulation under anesthesia with subacromial and glenohumeral injection.

Clinical Rationale

First of all in this case, the medical records adequately documented that the patient underwent an injection procedure on 2.1.05, and the performing orthopedist recommended 4 weeks of post-injection therapy. The dates in question here correspond to that post-injection prescription and recommendation, so the treatment rendered was initially supported as medically necessary based on protocol.

Upon careful review of the examination findings, the records demonstrated that the patient's range of motion improved under the care provided. Specifically, the examinations on 2.8.05 and then again on 2.18.05, and then the physical performance evaluation (PPE) on 3.11.05, documented that right shoulder flexion was recorded at 160/160/165 [all in degrees], respectively over those dates; also, extension went from 25/30/35, internal rotation went from 65/60/65, and external rotation went from 30/30/60. Abduction went from 150 on 2.8.05 to 160 on the PPE (adduction didn't change between those testing dates). As a result, the care rendered fulfilled the statutory requirements¹ for medical necessity since promotion of recovery was accomplished.

Finally, a designated doctor evaluated the patient on 4.12.05 and it was his opinion following that examination that the patient had *not* reached maximum medical improvement. Also, not only did he believe that additional diagnostic testing was still necessary at that point, but he actually stated in his report, "I would like to see her continue her physical therapy, especially to increase the range of motion on the right shoulder to full abduction." Even on 4.12.05 – a date well after the dates of service in dispute here – a doctor whose opinion carries presumptive weight felt that additional, similar treatment was medically necessary.

Therefore, it is the opinion of this reviewer that the medical records substantiate medical necessity for the disputed care in this case.

Clinical Criteria, Utilization Guidelines or other material referenced

Texas Labor Code 408.021

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.

¹ Texas Labor Code 408.021

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 15th 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.