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

Type of Requestor: (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address: Ergonomic Rehabilitation of Houston 283 Lockhaven, Suite 315 Houston, Texas 77073	MDR Tracking No.: M5-05-3090-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Zurich American Insurance Company C/O Flahive-Ogden-Latson Box 19	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: TWCC-60 package, explanations of benefits, CMS 1500s and proof of reconsideration submission
POSITION SUMMARY: Fee reimbursement/retrospective medical necessity per TWCC-60

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to TWCC-60 and copy of peer review
POSITION SUMMARY: "This is a fee dispute involving retrospective medical necessity. The carrier disputes that the provider has shown that the treatment underlying the charges was medically reasonable and necessary. Further, the carrier challenges whether the charges are consistent with applicable fee guidelines".

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
12-08-03 to 12-10-03 and 12-15-03 to 01-09-04	Work hardening and work hardening each additional hour	☐ Yes ☒ 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 10-07-05, 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.

Review of CPT code 97750-FC (3 units) date of service 01-16-04 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 an EOB. Reimbursement is recommended in the amount of **$110.25 ($29.40 X 125% = $36.75 X 3 units).**

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 133.307(e)(2)(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 entitled to reimbursement in the amount of $110.25. 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. In addition the Division finds the requestor was not the prevailing party and is not entitled to a refund of the IRO fee.

Findings and Decision and Order by:

		10-11-05
Authorized Signature		Date of Findings and Decision and 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.

Amended: October 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: M5-05-3090-01
RE: Independent review for ___

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

- Parker Healthcare Management received notification of independent review on 8.18.05.
- Faxed request for provider records made on 8.18.05.
- The case was assigned to a reviewer on 9.9.05.
- The reviewer rendered a determination on 9.27.05.
- The Notice of Determination was sent on 9.29.05.
- The Texas Department of Insurance/Workers Compensation division requested amendment on 10.7.05.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of work hardening: 97545-WH-CA and 97546-WH-CA
Dates of service in dispute: 12.08.03-1.9.04
Services noted on the Table of disputed charges as "FEE" issues 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 injury on ___, while employed with ..

Clinical Rationale

Prior to the work-hardening program, Ms. ___ had undergone physical therapy & chiropractic treatments. These services should have been sufficient enough to not only provide her with relief of her symptoms, but to educate her on body mechanics, proper posture, as well as instruct her in a home exercise program to be carried out at the discretion of the clinicians.

On November 13, 2003, Ms. ___ was evaluated by neurosurgeon, Dr. David MacDougall. In his notes on this date he states: "Treatments have consisted of physical therapy, which has been carried out by Dr. Brando. This has improved her condition immensely. She (Ms. ___) relates that the symptoms have declined significantly".

This neurosurgical evaluation occurred prior to the initiation of any work hardening, and is evidence of significant enough improvement in Ms. ___' condition that would preclude the necessity of a work hardening program.

Based on the above information and my professional clinical judgment of this case, my determination is to uphold the denial of reimbursement as set forth by the URA on this case.

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.

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 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 the Texas Department of Insurance/Workers Compensation division applicable to Commission Rule 102.5 this 29th 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.