



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 Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address: Texas Imaging & Diagnostic Center 3840 W. Northwest Highway # 400 Dallas, Texas 75220	MDR Tracking No.: M5-05-3111-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Dallas Fire Insurance Company Box 17	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: TWCC-60 package, CMS 1500, explanation of benefits
POSITION SUMMARY: "The insurance company has not reimbursed us for the procedure(s) on the above date(s) of service ordered from the referring doctor, Dr. Ghada Koudsi, D.C."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to TWCC-60, explanation of benefits, peer review and designated doctor examination
POSITION SUMMARY: "In conclusion, there is no documentation to support the medical necessity of the disputed treatment and the Requestor is owed no reimbursement for that treatment"

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
05-24-05	72141	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$700.40

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 **\$700.40 (\$560.32 X 125%)**.

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 additional reimbursement in the amount of \$700.40. 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.

Ordered by:

Medical Dispute Officer

10-06-05

Authorized Signature

Typed Name

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.

September 30, 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: M5-05-3111-01
RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 8.25.05.
- Faxed request for provider records made on 8.25.05.
- The case was assigned to a reviewer on 9.15.05.
- The reviewer rendered a determination on 9.28.05.
- The Notice of Determination was sent on 9.30.05.

The findings of the independent review are as follows:

Questions for Review

The services in question are an MRI to the cervical spine w/o contrast. The reason for denial is listed as a lack of medical necessity. The date of service is listed as 5.24.05.

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 the disputed service(s).

Summary of Clinical History

The patient is suffering from a work related cervical spine injury with documented progressive and ongoing injury.

Clinical Rationale

The patient had significant symptoms from the onset, however not severe. Over a period of time the symptoms did not improve and actually got worse. The additional symptoms included not only the initial complaints, but radiating symptoms in the upper extremity. The fact that the symptoms persisted, spread and got worse over a period of time, despite provided therapy, is a definite reason to conduct other investigative studies to determine the etiology of the symptoms. These additional studies would include an MRI.

Dr. Weigel did an RME on the patient and stated in the findings of her report that the patient has a normal cervical spine MRI. The MRI report actually shows the patient had a documented Chiari I malformation with 5 mm of tonsillar ectopia. The tonsils actually descend to the level of the posterior arch at C1 and cause possible compression at the level of C1. There is also a minimal bulge at C4-5, but does correlate with the level of the symptoms in the C5 myotome or the patient's shoulder and scapular area. When

reviewing the RME report, several clinical indicators that would show a possible upper motor lesion or myelopathy, that could be as a result of rostral or upper cervical cord compression from the chiari malformation, were not present. This would include comments on plantar responses, abdominal responses, possible limb spasticity and the reflexes were listed as symmetric, but not graded to their response. There also were no comments in regards to a suprasegmental cranial evaluation for possible complications from a Chiari malformation.

In conclusion, due to the patient's persistent symptoms including radiating pain, despite therapy, would warrant more investigative studies.

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 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 30th 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.