



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: Rehab 2112 P O BOX 671342 Dallas, Texas 75267-1342	MDR Tracking No.: M5-05-3174-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: American Casualty Company Box 47	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: TWCC-60, CMS 1500s and explanations of benefits
POSITION SUMMARY: "Services are medically necessary" per the table of disputed services

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to TWCC-60 and copy of PEER review
POSITION SUMMARY: None submitted by Respondent

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
08-25-04 to 11-09-04	97545-WH-CA (1 unit @ \$128.00 X 36 = \$4,608.00) 97546-WH-CA (5 units @ \$320.00 X 27 = \$8,640.00) (4 units @ \$256.00 X 6 = \$1,536.00) (3 units @ \$192.00 X 2 = \$384.00) (3 units @ \$16.00 = \$48.00 X 3 = \$144.00) (1 unit @ \$16.00 X 2 = \$32.00) (2 units @ \$32.00 X 3 = \$96.00) 97750-FC (8 units @ \$296.00 X 1 = \$296.00)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$15,736.00

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 **prevailed** on the disputed medical necessity issues.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and Rule 134.202

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 \$15,736.00. 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 by:

10-24-05

Authorized Signature

Date of Findings and Decision

Order by:

10-24-05

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.

October 17, 2005

ATTN: Program Administrator
Texas Department of Insurance/Workers Compensation Division
7551 Metro Center Drive, Suite 100
Austin, TX 78744
Delivered by fax: 512.804.4868

Notice of Determination

MDR TRACKING NUMBER: M5-05-3174-01
RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 9.02.2005.
- Faxed request for provider records made on 9.05.05.
- TDI/DWC issued an Order for Documents on 9.22.2005.
- The case was assigned to a reviewer on 9.29.2005.
- The reviewer rendered a determination on 10.17.2005.
- The Notice of Determination was sent on 10.17.2005.

The findings of the independent review are as follows:

Questions for Review

The therapies in dispute include a work hardening program and functional capacity study. The dates in question are from 8.25.04 through the date of 11.9.04. The date of injury is listed as ____.

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 requested service(s).

Summary of Clinical History

The claimant was injured as a result of a work related accident. He was apparently trying to cross the street to pick ups some trash and when he was struck by a passing car in the side. The vehicle ran over his feet also. As he fell, he struck his head on the ground. Since that time period, the claimant has received various forms of treatment and diagnostic tests.

Clinical Rationale

The claimant has a necessary PDL that is listed as heavy. This is referenced and appears to be an accurate description of the necessary PDL of the claimant. The functional studies before the recommended program revealed the need for tertiary care. He initially was not at the required PDL of heavy; he was only capable of lifting in the light PDL. The patient's lifting capabilities, range of motion and psychological issue(s) all needed to be addressed. The claimant went through the work hardening program and as a result was able to achieve functional status in the heavy PDL and ultimately is reported as having returned back to work. This reveals that the services were not only medically necessary, but effective as well. The FCE would be necessary in order to monitor patient progression so it would be necessary as well.

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 Texas Department of Insurance /Division of Workers' Compensation. In accordance with the act and the rules, the review is listed on the DWC'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, the injured employee, injured employee's insurance carrier, the URA or any 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 Texas Department of Insurance /Division of Workers Compensation applicable to Commission Rule 102.5 this 17th day of October, 2005. The Division of Workers Compensation 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.