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: Rehab 2112 P O BOX 671342 Dallas, Texas 75267-1342	MDR Tracking No.: M5-05-3305-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: AMERICAN HOME ASSURANCE COMPANY BOX 19	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60 dispute package
POSITION SUMMARY: Per the table of disputed services "services were medically necessary"

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60
POSITION SUMMARY: No further payment was recommended towards the amount in dispute. Please see the attached Explanations of Benefits Reports.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
10-14-04 to 12-03-04	97545-WH-CA, 97546-WH-CA and 97750-FC	☐ 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 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 10-19-05, 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 97546-WH-CA on 10-27-04 and 11-03-04 denied with denial code "F" (fee schedule MAR reduction). The carrier has made no payment. The IRO reviewer stated in the IRO decision that it was not felt that the criteria to support work hardening was present. The IRO decision is considered a Division decision per Rule 133.308(p)(5) and on this basis no reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and Rule 133.308(p)(5)

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:

		12-16-05
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.

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: M5-05-3305-01
RE: Independent review for ___

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

- Parker Healthcare Management received notification of independent review on 9.19.2005.
- Faxed request for provider records made on 9.21.2005.
- The case was assigned to a reviewer on 10.5.2005.
- The reviewer rendered a determination on 10.14.2005.
- The Notice of Determination was sent on 10.17.2005.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of the Functional Capacity Exam-97750-FC, work hardening 97545-WH-CA and each additional hour of work hardening 97546-WH-CA…Dates in review: 10.14.2004-12.03.2004

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

The claimant is listed as being injured on ___. The patient is suffering from injuries to the left shoulder area. Since the time of the injury, the claimant has received different aspects of therapy and diagnostics. The claimant entered into a work hardening program and was discharged to modified duty.

Clinical Rationale

The claimant is listed as having to perform in the heavy PDL. His FCE has him listed in the medium category. The FCE's, however, do not accurately record his dynamic lifting capabilities. Typically the Hanoun system will use the epic dynamic lifting protocol and will give frequent and occasional classifications. This is a very accurate way to determine lifting status. On the FCE's for this individual, there is just mention of the floor to knuckle, knuckle to shoulder and floor to shoulder testing. There was no mention if it is frequent or constant or occasional and this breaks the protocol used to accurately determine lifting status or PDL. As a result, I looked at the static lifting capabilities of the patient. These are not typically used to determine lifting status because they are not dynamic. However, one thing that is noted is that this individual can statically lift well into the hundreds on many lifts and has stable torque curves. Having said this, I do not feel that the criteria to support work hardening are present. I do not feel that his personal PDL or capabilities were accurately recorded and I do not feel that the testing, imaging and the given diagnoses reflect the need for tertiary care.

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

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The reviewer for this case is a doctor of chiropractic peer matched with the provider that rendered the care in dispute. The reviewer is a diplomate of the American Chiropractic Neurology Board, and serves as an Associate Professor with the Carrick Institute. 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.

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Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.