



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: <input checked="" type="checkbox"/> Health Care Provider <input type="checkbox"/> Injured Employee <input type="checkbox"/> Insurance Carrier	
Requestor's Name and Address: Pain & Recovery Clinic of North Houston 6660 Airline Drive Houston, Texas 77076	MDR Tracking No.: M5-05-3308-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Service Lloyds Insurance Company Box 42	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 1500s and explanations of benefits
POSITION SUMMARY: No position summary submitted by the Requestor

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to TWCC-60
POSITION SUMMARY: No position summary submitted by the Respondent

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
11-01-04 to 11-29-04	97110, 97112, 97140 and 99212	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308

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:

10-31-05

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 25, 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: M5-05-3308-01
RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 9.13.05.
- Faxed request for provider records made on 9.13.05.
- The case was assigned to a reviewer on 10.05.05.
- The reviewer rendered a determination on 10.21.05.
- The Notice of Determination was sent on 10.25.05.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of therapeutic exercises (97110), neuromuscular re-education (97112), manual therapy (97140), and office visits (99212). DOS in review: 11.1.04-11.29.04

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 sustained a work related injury on ____, when he fell from a height of 14 feet to the ground. He is listed as having injuries to his skull, right wrist, cervical, thoracic and lumbar spinal areas. Apparently, there is documentation of a skull fracture. There was an MRI to the lower back, which only demonstrated minimal findings and the cervical spine MRI was normal. An EMG was performed was done by John Mullen, PT, which resulted in the diagnosis of a medial branch lesion of the brachial plexus. These findings are inconsistent with the outcomes of his study. He found pathology in the left deltoid and 1st dorsal and ADM. These different muscles are from two completely different portions of the brachial plexus, one being from the medial cord leading to the branch of the ulnar nerve (1st dorsal / ADM), the other being a posterior cord derivative leading to the branch of the axillary and radial nerve, which innervates the (Deltoid) and other radial innervated muscles. The entire plexus was not evaluated, such as, the proximal portions of the brachial plexus that gives branches off of the roots and trunks. This would include the dorsal scapular, long thoracic and suprascapular nerves which would rule in or out other types of plexus lesions such as an Erb's palsy or other proximal plexus pathology. The actual given EDX diagnoses are not completely supported by the given study and seem highly unlikely given the pattern of muscles noted during the EMG. Per the records, there has been a request for another study. There have also been functional studies and a lower extremity study. There have also been requests for tertiary care such as work hardening.

Clinical Rationale

During the time period in question, the type of therapy provided offered little to no impact in regards to recovery. Despite the

therapy, the patient still has pain, weakness and dysfunction that is similar to the time of onset of the injury. As a result, a continuation of active care for such a long time period without a real change in objective findings leads to the conclusion that medical necessity was not established.

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 a diplomate of the American Chiropractic Neurology Board, and serves as an Associate Professor with the Carrick Institute. The reviewer has added credentials in clinical nutrition, rehabilitation and electrodiagnostic medicine. 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 the treating and/or referring provider, the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO.

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 25th 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.