



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: Metrohealth Resources/Americare Clinics 3500 Oak Lawn Suite 380 Dallas, Texas 75219	MDR Tracking No.: M5-05-3312-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Box 42	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 table of disputed services "Medically Necessary"

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60
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)
09-01-04 to 09-03-04	99203, 73110-WP, 99212, 97110-GP, 95851-59 and 97140-GP	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$691.06
10-08-04 to 10-21-04	99212, 97530-GP, 97110-GP and 97150	<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 majority of 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 09-19-05, 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 99212 date of service 11-24-04 denied with denial code "W4" (no additional reimbursement allowed after review of appeal/reconsideration). The requestor did not submit documentation supporting the service billed per Rule 133.307(g)(3)(A-F). No reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and Rule 133.307(g)(3)(A-F)

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 \$691.06. The Division finds that the requestor was not the prevailing party and is not entitled to a refund of the IRO fee. 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:

12-16-05

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 26, 2005

Amendment: October 28, 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: M5-05-3312-01

RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 9.16.05.
- Faxed request for provider records made on 9.16.05.
- The case was assigned to a reviewer on 10.05.05.
- The reviewer rendered a determination on 10.24.05.
- The Notice of Determination was sent on 10.26.05.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of codes: 99203/99212 (office visits), 73110-WP (x-ray), 97110 (Therapeutic exercises), 95851-GP(ROM measurements), 97140-GP(manual therapy), 97530-GP (therapeutic activities). Items denied for "FEE" issues were not reviewed.

Dates in Dispute: 9.1.2004-10.21.2004

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 **overturn the denial** on the all of the disputed service(s) that occurred from 9.01.2004-10.01.2004.

The PHMO, Inc. physician reviewer has also determined to **uphold the denial** on all of the disputed service(s) that occurred between 10.02.2004-10.21.2004.

Summary of Clinical History

The claimant was employed by the _____ and was involved in a work related event that occurred on _____. Claimant presented to Christopher Plate DC/AmeriCARE Clinics on 09.01.04, a diagnosis of tenosynovitis/sprain unspecified of the wrist was rendered and a full recovery was expected for the diagnosed condition. A trial of passive care including joint mobilization, soft tissue mobilization was advised coupled with a course of active rehabilitation therapeutics. Claimant engaged in trial of hand exercise including therapeutic, theraweb, and theraball applications. Chiropractic provider also engaged in dynamic applications including lower body ergometer trials noted on/about 10.01.04. Functional Capacity Evaluation was performed on 12.06.04 that revealed the claimant was capable of function within a sedentary physical demands classification.

Clinical Rationale

The data reviewed establishes a clinical diagnosis that warrants the provider's initial evaluation procedures and treatment algorithm. Chiropractic provider implemented duration of passive therapeutics that transitioned into active therapeutics for the management of claimant's pain generators.

There is no qualitative/quantitative medical data that establishes efficacy to warrant the trail of chiropractic management beyond 10.01. Chiropractors must be able to determine when care is clinically necessary, when care is leading to progress, and when the patient has failed to continue to respond to a particular treatment plan (Overview of implementation of outcome assessment case management in the clinical practice).

In this case, the provider failed to establish necessity of care through referral or with diagnostic testing.

Clinical Criteria, Utilization Guidelines or other material referenced

- Moore JS. De Quervain's tenosynovitis. Stenosing tenosynovitis of the first dorsal compartment. *J Occup Environ Med.* 1997 Oct;39(10):990-1002.
- Overview of implementation of outcome assessment case management in the clinical practice. Washington State Chiropractic Association; 2001. 54 p. [180 references].
- Troyanovich SJ, et al. Structural rehabilitation of the spine and posture: rationale for treatment beyond the resolution of symptoms. *J Manipulative Physiol Ther.* 1998 Jan;21(1):37-50.
- Winzeler S, et al. Occupational injury and illness of the thumb. Causes and solutions. *AAOHN J.* 1996 Oct;44(10):487-92.

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 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 TDI-DWC department applicable to Commission Rule 102.5 this 26th day of October, 2005. The DWC 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.