



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: Pain & Recovery C/o Bose Consulting P O BOX 550496 Houston, Texas 77255	MDR Tracking No.: M5-06-0033-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Insurance Company Box 54	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: On November 11, 2004, the claimant was evaluated by Dr. Metzger, an orthopedic surgeon, who recommended that the claimant post-surgical therapy. The above indicates that the treatment provided for the claimant was medically reasonable and necessary. We are requesting reimbursement for all disputed dates of services.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60
 POSITION SUMMARY: This dispute involves the carrier's payment for date of service 9/13/2004 to 1/19/2005. The requester billed \$4,955.91; Texas Mutual paid \$0.00. The requester believes it is entitled to an additional of \$4,955.91.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
09-13-04 to 01-19-05	97032, 97140, 99212, 97112, 97110 and 97002	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$4,956.06

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(c)(1)

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 \$4,956.06. 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:

12-19-05

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.

December 1, 2005
Amended: December 16, 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: M5-06-0033-01
RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 10.21.05.
- Faxed request for provider records made on 10.24.05.
- The case was assigned to a reviewer on 11.14.05.
- The reviewer rendered a determination on 11.30.05.
- The Notice of Determination was sent on 12.01.05.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of the following procedures: 97032- electrical stimulation, 97140-manual therapy technique, 99212-office visits, 97112-neuromuscular reeducation, 97110-therapeutic exercises, 97002-physical therapy re-evaluation. Dates of service: 9.13.04-1.19.05.

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 all of the disputed service(s).

Summary of Clinical History

Mr. ____ sustained a work related job injury on ____, while employed with ____.
He suffered extensive on-the-job injuries, underwent emergency surgery for ORIF of the right Ulna & Radius, and in my opinion progressed in Physical Therapy in a customary and timely fashion, given the extent of his injuries.

Clinical Rationale

All of the treatments carried out by the Physical Therapist, in this case, were both reasonable and medically necessary in order for this man to progress as well as he did. It is not reasonable or sufficient to expect a patient with this type of injury to recover in an acceptable manner with just a home exercise program. 3-6 months of therapy is well within acceptable guidelines of care for this patient. Hands on, one-to-one therapy is the most clinically sound treatment to necessitate a timely recovery in most cases, especially when there are multiple orthopedic issues as well as neuro-vascular involvement, as there was in this particular case.

Based on the above information and my own sound clinical judgment and experience, it is my decision to overturn the denial of reimbursement for all disputed charges as set forth by the insurance company.

Clinical Criteria, Utilization Guidelines or other material referenced

This conclusion is supported by the reviewers' clinical experience as a Physical Therapist with over 5 years of experience.

The reviewer for this case is a Physical Therapist peer matched with the provider that rendered the care in dispute. The reviewer is engaged in the practice of physical therapy 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 1st day of December 2005. This determination was amended on the 16th day of December 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.

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.