



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

<b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address: Pain & Recovery Clinic of North Houston 6660 Airline Drive Houston, Texas 77076	MDR Tracking No.: M5-06-0041-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Gray Insurance 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 package, CMS 1500s and explanations of benefits  
 POSITION SUMMARY: From the table of disputed services "All treatments and services were rendered in good faith to treat the injured employee's compensable injuries and were all reasonable and necessary."

#### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60  
 POSITION SUMMARY: This is a fee dispute involving retrospective medical necessity. The carrier disputes that the provider has shown that the treatment underlying the charges was medically reasonable and necessary. Further, the carrier challenges whether the charges are consistent with applicable fee guidelines. The carrier asserts that it has paid according to applicable fee guidelines. All reductions of the disputed charges were appropriately made. Further, the documentation provided does not establish medical necessity.

#### 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 11-10-04	99212, 97110, 97140 and 97112	<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:

11-16-05

\_\_\_\_\_  
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.**

November 8, 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: M5-06-0041-01  
RE: Independent review for \_\_\_\_

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

- Parker Healthcare Management received notification of independent review on 9.30.05.
- Faxed request for provider records made on 9.30.05.
- The case was assigned to a reviewer on 10.18.05.
- The reviewer rendered a determination on 11.07.05.
- The Notice of Determination was sent on 11.08.05.

The findings of the independent review are as follows:

### Questions for Review

Medical necessity of 99212-Office visits, 97110-therapeutic exercises, 97140-manual therapy technique, and 97112-neuromuscular reeducation... Dates in dispute: 9.01.04-11.10.04

### 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 all of the reviewed service(s).

### Summary of Clinical History

The claimant was injured as a result of a work related accident while working for . He was apparently getting out of his truck and while doing this fell down and landed on his right knee. This twisted his body and injured the right knee. Since then the claimant has had a surgical procedure on the right knee on the date of 2.26.04. Post surgical rehabilitation began on the date of 3.31.04. From the date of 3.31.04 until the date of 11.10.04 the claimant had approximately 76 visits of chiropractic and post surgical care. The claimant has also been given an MRI, various forms of conservative and non-conservative care as well as consultations, including a designated doctor reporting which MMI was established on the date of 1.31.05 with an 8% whole person impairment. The MRI that was performed demonstrated significant damage on the MRI. This included ACL damage, medial meniscus damage, osteochondral and contusion to the lateral femoral condyle, damage to the popliteus muscle and contusion to the tibial plateau.

### Clinical Rationale

On 9.1.04, the claimant had reduced range of motion, tenderness, gait alteration and weakness. On 11.10.04 there was still reduced range of motion, tenderness, gait alterations and weakness in the right lower extremity. There appears to be no clear benefit from the therapy given during this time period based upon review of the daily progress notes. Continuing therapy without any substantial documented improvement way outside of the typical treatment time frames for a post surgical knee is not reasonable.

The only physical therapy progress notes that are available during the time period in question are on the dates of 8.11.04 and 10.01.04. During this time, the subjective complaints and pain scale are the same. The range of motion is almost identical and the strength is still the same as well and the aggravating factors are also the same. It appears that improvement slowed down after the 6.09.04 evaluation that was performed by the physical therapist. As a result, continuing care that is not offering any significant benefit to the claimant cannot be supported.

## 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 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 8<sup>th</sup> day of November, 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.

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Meredith Thomas  
Administrator  
Parker Healthcare Management Organization, Inc.