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: Richard Stephenson, D.C. 322 N. Main Street Bryan, Texas 77803	MDR Tracking No.: M5-06-0047-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Box 45	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 "within guidelines"

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

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

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
04-05-05 to 05-02-05	97035 and 99213	☒ Yes ☐ No	$880.38

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.

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 10-21-05, 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 97032 (2 units each DOS for a total of 12 units) dates of service 04-11-05, 04-13-05, 04-15-05, 04-18-05, 04-21-05 and 04-22-05 denied with denial code "175" (services have been previously paid). The carrier has made a total payment of $114.00. Additional reimbursement is recommended in the amount of **$46.92 ($7.82 X 6 DOS).**

CPT code 97124 (2 units each DOC for a total of 8 units) dates of service 04-27-05, 04-28-05, 04-29-05 and 05-02-05 denied with denial code "175" (services have been previously paid). The carrier has made a total payment of $106.52. Additional reimbursement is recommended in the amount of **$106.52.**

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 $1,033.82. 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:

		12-22-05
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 19, 2005
Amended: October 20, 2005

ATTN: Program Administrator
TDI/Division of Workers Compensation
7551 Metro Center Drive, Suite 100
Austin, TX 78744
Delivered by fax: 512.804.4868

Notice of Determination

MDR TRACKING NUMBER: M5-06-0047-01
RE: Independent review for ___

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

- Parker Healthcare Management received notification of independent review on 9.23.05.
- Faxed request for provider records made on 9.23.05.
- The case was assigned to a reviewer on 10.05.05.
- The reviewer rendered a determination on 10.18.05.
- The Notice of Determination was sent on 10.19.05.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of 97035-ultrasound and 99213-office visit. Dates of service for review: 4.5.05-5.2.05
"FEE" denied items were not reviewed.

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 requested service(s).

Summary of Clinical History

Ms. ___ sustained a work related job injury on ___, while employed with the .

Clinical Rationale

Physical medicine is an accepted part of a rehabilitation program following an injury. The *Guidelines for Chiropractic Quality Assurance and Practice Parameters* 1 Chapter 8 under "Failure to Meet Treatment/Care Objectives" states, "After a maximum of two trial therapy series of manual procedures lasting up to two weeks each (four weeks total) without significant documented improvement, manual procedures may no longer be appropriate and alternative care should be considered." The ACOEM Guidelines 2 state that if treatment does not bring improvement in three to four weeks, it should be stopped and the patient reevaluated. Since all the disputed treatment occurred during that first 4-week period, the care in question was both indicated and medically necessary.

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1 Haldeman, S; Chapman-Smith, D; Petersen, D *Guidelines for Chiropractic Quality Assurance and Practice Parameters,* Aspen Publishers, Inc.
2 *ACOEM Occupational Medicine Practice Guidelines: Evaluation and Management of Common Health Problems and Functional Recovery in Workers, 2nd Edition*, p. 299.

Clinical Criteria, Utilization Guidelines or other material referenced

- The *Guidelines for Chiropractic Quality Assurance and Practice Parameters*
- ACOEM Guidelines

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 the Texas Workers Compensation Commission. In accordance with the act and the rules, the review is listed on the TWCC'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 applicable to Commission Rule 102.5 this 19th day of October, 2005. The TDI/DWC 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.