



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:  
Carlos X. Domino, D.C.  
P O BOX 550496  
Houston, Texas 77255

MDR Tracking No.: M5-06-0511-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:  
Ace American Insurance Company  
Box 15

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

#### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION: DWC-60 dispute package

POSITION SUMMARY: The above claimant sustained a work-related injury on \_\_\_\_\_. Carols X Domino (Provider) provided treatment to the above claimant for the work-related injury sustained on \_\_\_\_\_. The provider timely billed the carrier for the treatment provided to the above claimant between May 6, 2005 through August 29, 2005 (Disputed Dates of Service). The carrier denied reimbursement to the provider for the disputed dates of service.

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

DOCUMENTATION: 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)
05-06-05 to 08-29-05	97110 (\$71.72 X 1) = \$71.72	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$6,360.40
	97110 (\$143.44 X 37) = \$5,307.28		
	97110 (\$107.58 X 1) = \$107.58		
	97140 (\$101.82 X 3) = \$305.46		
	97140 (\$135.76 X 3) = \$407.28		
	98941 (\$46.94 X 2) = \$93.88		
	99213-MP (\$67.20 X 1) = \$67.20		
05-06-05 to 08-29-05	97035, 97024 and 97535	<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 **prevailed** 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 12-01-05, 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.

Review of CPT code 99080-73 date of service 05-06-05 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the requestor did not submit convincing evidence of carrier receipt of the providers request for an EOB. No reimbursement is recommended.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. 133.308, 134.202(c)(1), 133.307(e)(2)(B)

**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 additional reimbursement in the amount of \$6,360.40. 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.

Findings and Decision by:

01-04-06

Date of Findings and Decision

Order by:

01-04-06

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 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: M5-06-0511-01  
RE: Independent review for \_\_\_\_

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

- Parker Healthcare Management received notification of independent review on 12.01.05.
- Faxed request for provider records made on 12.1.05.
- The case was assigned to a reviewer on 12.15.05.
- The reviewer rendered a determination on 12.28.05.
- The Notice of Determination was sent on 12.28.05.

The findings of the independent review are as follows:

#### Questions for Review

The clinical questions to be resolved include the medical necessity of 97110 (Therapeutic Exercise), 97035 (Ultrasound), 97140 and 97140-59 (Manual Therapy), 97535 (Self Care Management Training), 98941 (Chiropractic Manipulation), 99213-MP (Office Visit), 97024 (Diathermy). The dates of service that are under review include 5.6.05 through 8.29.05. The date of injury is listed as \_\_\_\_\_. The therapy in question occurred approximately 6 months after the date of injury.

#### 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 denied service(s) to include: 97110 (Therapeutic Exercise), 97140 and 97140-59 (Manual Therapy), 98941 (Chiropractic Manipulation) and 99213-MP (Office Visit).

The PHMO, Inc. physician reviewer has also determined to **uphold the denial** on all of the denied service(s) to include: 97035 (Ultrasound), 97024 (Diathermy) and 97535 (Self Care Management Training).

#### Summary of Clinical History

The claimant was injured while working for \_\_\_\_\_ as a laborer. The claimant sustained right elbow pain after lifting a large trash can. There apparently was a torn biceps tendon that completely detached from the proximal radius. On 4.20.05, the designated states that the claimant was not at MMI, but on the follow up visit it was stated that the claimant had full motion, good movement and was back at work. The claimant reached MMI on the date of 7.13.05 with a 1% whole person impairment. The examination was done by George Lane MD, the designated doctor. On 8.22.05 the claimants' surgeon stated that there would be an expected nine to ten months for complete healing of the injured right elbow.

#### Clinical Rationale

The claimant clearly needed active care and there was clear improvement during the course of treatment in regards to range of motion and reduction in pain during the time period in question. Active care 6 months after the date of injury

and surgery procedure is at times reasonable, especially in this given situation where there was a complete biceps rupture. Passive care well outside of the acute and sub-acute phases of care is not supported nor can the documentation demonstrate that passive care specifically had anything to do with the improvement of the claimant. There was no documented exacerbation that I could find that would lead to the need for more acute care. As a result, active care is reasonable and executed during the appropriate time frame, passive modalities however were not. The training for at home exercises is standard as part of any rehabilitation program and should be considered as an inclusive part of communicating with the patient.

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 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 28<sup>th</sup> 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.

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Meredith Thomas  
Administrator  
Parker Healthcare Management Organization, Inc.