



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

<b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address: James Todd Boyd, D.C., DABCO 2310 N. Expressway 83 Brownsville, Texas 78526	MDR Tracking No.: M5-06-0579-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: American Home Assurance 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 dispute package  
POSITION SUMMARY: Per the table of disputed services "Medically Necessary. See attached"

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

DOCUMENTATION SUBMITTED: Response to DWC-60  
POSITION SUMMARY: No position summary 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)
11-15-04 to 02-11-05	98940 (\$31.35 X 13) = \$407.55	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$959.95
	97039 (35.00 X 13) = \$455.00		
	99214-25 (97.40 X 1) = \$97.40		

#### 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 02-08-06, 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.

Date of service 11-12-04 per Rule 133.308(e)(1) was not timely filed and will therefore not be a part of the review.

CPT code 97039 date of service 12-01-04 denied with ANSI denial code "16" (Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.) Per Rule 133.307(g)(3)(A-F) the requestor submitted documentation supporting the service in dispute. Reimbursement is recommended in the amount of **\$35.00**.

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

28 Texas Administrative Code Sec. 133.308 and 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 \$994.95. 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:

02-23-06

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

January 27, 2006

**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: \_\_\_\_\_  
RE: Independent review for M5-06-0579-01

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

- Parker Healthcare Management received notification of independent review on 12.20.05.
- Faxed request for provider records made on 12.20.05.
- The case was assigned to a reviewer on 1.9.06.
- The reviewer rendered a determination on 1.25.06.
- The Notice of Determination was sent on 1.27.06.

#### Questions for Review

The clinical questions to be resolved are medical necessity for the following services: Chiropractic manipulation (98940), unlisted modality (97039)(Flexion Distraction) and Office visits (99214-25). These services are in dispute from the listed dates of 11.15.04 until 2.11.05. The items denied as "FEE" were not included in this review.

#### 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 eligible disputed services.

#### Summary of Clinical History

On 3.22.04, the patient has surgery performed by Dr. Alexander of Houston, TX. Dr. Boyd, D.C., started treating the claimant on 9.17.04. Therapeutic exercises began on 9.24.04. Apparently there was only three days rehabilitation services offered or authorized due to insurance denial. He participated in a work hardening program from 1.3.05-2.2.05. The patient was examined twice for MMI and impairment.

#### Clinical Rationale

The office visits were necessary in order monitor progress and direct the care appropriately. The majority of the care provided was flexion distraction and chiropractic care. During the time in dispute, the services provided did objectively demonstrate a reduction in pain based upon the health questionnaire and the quadruple visual analog scale. Also, orthopedic findings had reduced and various aspects of physical function improved. There are still residual symptoms, but improvement clearly was demonstrated. Therefore, the care provided (despite research studies and "guideline" recommendations) demonstrably improved the patient's condition. Medical necessity was established according to the criteria outlined in Texas Labor Code §408.021.

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 27<sup>th</sup> day of January, 2006. 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.