



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: Horizon Health c/o Bose Consulting LLC P O BOX 550496 Houston, Texas 77255	MDR Tracking No.: M5-06-0670-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Zenith Insurance Company Box 47	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 "Necessary Treatment"

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60
POSITION SUMMARY: "Zenith continues to believe that the disputed services were not medically necessary".

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
04-11-05 to 04-22-05	99212 (\$48.03 X 6 DOS = \$288.18)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,895.52
	97110 (5 units @ \$179.30 X 3 DOS = \$537.90)		
	97110 (6 units @ \$215.16 X 3 DOS = \$645.48)		
	97112 (\$36.75 X 6 DOS = \$220.50)		
	97140 (\$33.91 X 6 DOS = \$203.46)		
04-25-05 to 05-26-05	99212, 97110, 97112 and 97140	<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 **majority** of the disputed medical necessity issues.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 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 \$1,895.52. The Division finds that the requestor was not the prevailing party and is not entitled to a refund of the IRO fee. 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:

02-14-06

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.

February 13, 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: M5-06-0670-01
RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 12.23.05.
- Faxed request for provider records made on 12.27.05.
- TDI-DWC issued an Order for Payment on 1.3.06.
- The case was assigned to a reviewer on 1.18.06.
- The reviewer rendered a determination on 2.10.06.
- The Notice of Determination was sent on 2.13.06.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of office visits (99212), therapeutic exercises (97110), neuromuscular reeducation (97112) and manual therapy (97140) for dates of service 04.11.05 – 5.26.05.

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 the disputed service(s): office visits (99212), therapeutic exercises (97110), neuromuscular reeducation (97112) and manual therapy (97140) through date of service 4.22.05.

The PHMO, Inc. physician reviewer has also determined to **uphold the denial** on the all of the disputed service(s) that occurred after date of service 4.22.05.

Summary of Clinical History

The patient sustained a work related job injury on ____, while employed with _____.

Clinical Rationale

Passive modalities for rehabilitation are rarely indicated for more than 3-6 visits. Therefore, 6 visits of office visits (99212), therapeutic exercises (97110), neuromuscular reeducation (97112) and manual therapy (97140) are approved as medical reasonable. After 6 visits, there needed to be strengthening exercises added to the treatment. Passive therapy alone would not provide adequate recovery and strengthening of the ankle. This is based on medically accepted protocols for rehabilitation of fractures of the ankle.

Clinical Criteria, Utilization Guidelines or other material referenced

- American Journal of Sports Medicine

This conclusion is supported by the reviewers' clinical experience with over 15 years of patient care.

The reviewer for this case is a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer is a diplomate of the American Board of Orthopedic Surgery, and is engaged in the full time practice of medicine.

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 13th day of February 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.

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.