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: San Antonio Accident/Injury Care 401 W. Commerce # 100 San Antonio, Texas 78207	MDR Tracking No.: M5-06-0821-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Insurance Company Box 54	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: None submitted by Requestor

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60
POSITION SUMMARY: "Texas Mutual requests that the request for dispute resolution filed by S A Accident/Injury, be conducted under the provisions of the APA set out above".

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
05-25-05 to 07-01-05	97113 (1 unit @ $4.86 X 5 = $24.30 and 1 unit @ $38.05 X 71 = $2,701.55)	☒ Yes ☐ N	$2,725.85
07-06-05 to 08-25-05	97124 and 97150	☐ Yes ☒ No	$0.00
	Note: Per Rule 133.308(p)(5) an IRO decision is deemed to be a commission decision and order		

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.

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 01-24-06, 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.

CPT code 99080 date of service 09-20-05 was listed on the table of disputed services. Per Rule 133.307(e)(2)(A) the requestor did not submit a copy of a CMS 1500 for review nor did the requestor provide documentation for review to support the services billed. No reimbursement recommended.

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 $2,725.85. In addition, 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:

		03-10-06
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.

March 7, 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: M5-06-0821-01
RE: Independent review for ___

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

- Parker Healthcare Management received notification of independent review by UPS on 2.1.06
- Faxed request for provider records made on 2.1.06.
- TDI-DWC issued an Order for Records on 2.14.06.
- The case was assigned to a reviewer on 2.28.06.
- The reviewer rendered a determination on 3.7.06.
- The Notice of Determination was sent on 3.7.06.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of aquatic therapy (97113), massage therapy (97124) and therapeutic procedures (97150). Dates in Dispute: 5.25.05-9.20.05

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 aquatic therapy (97113) from the dates of 5.25.05 through the date of 7.1.05.

The PHMO, Inc. physician reviewer has also determined to **uphold the denial** on the therapeutic procedures (97150) and massage (97124) from 7.6.05 through the date of 8.25.05.

Summary of Clinical History

The claimant was injured as a result of a work related accident that occurred on the date of ___. After this time period, the claimant had advanced imaging, diagnostic testing and conservative forms of care. The care administered included initial aquatic therapy, then progression to a land based active care program and then into a tertiary return to work program. After this, it is listed that the claimant returned back to work. The claimant was injured as a result of trying to bend over and lift up a large valve to carry to the end of the truck. As a result of doing this, the claimant was injured and suffered pain in the lower back and bilateral complaints that goes into both of the lower extremities. The right side has symptoms that appear to be worse and goes into the foot; the left side has symptoms that go just into the leg and not the foot.

Clinical Rationale

The patient has listed improvement over the course of the therapy and the goals of improvement and returning back to work were accomplished from the totality of therapy according to the rendering doctor. In specific, the aquatic therapy is listed to have reduced the level of pain and the documentation specifically reveals that the patient improved 41% from the aquatic therapy alone.

During this time, VAS scores levels reduced, radicular symptoms are described as having decreased. This makes aquatic therapy a viable, beneficial and necessary form of care. The notes submitted for aquatic therapy list details of exercises, the amount of

people

in each class as well as sets and reps and minutes in the pool. When considering the aforementioned, aquatic care appeared useful, beneficial and was necessary for the patient.

The first day of active therapy was listed on the Table of Disputed Services as 7.6.05. It is typical practice to progress from water to land based exercises. Initially the patient had a slight increase in pain from the initiation of the land based therapy. This is common when going from water to land. During the remainder of the active care however, there is no real compelling evidence in the documentation that the claimant improved from continued active, therapeutic procedures or massage. The claimant in the end still had pain that fluctuated from a 5/10 to a 3/10 and there were still symptoms that returned back into both legs with moderate frequency and aggravation still with various activities of daily life. It is unclear the progression and improvement during this time period with this type of care, based upon the documentation provided. When considering the aforementioned, the therapeutic procedures and massage therapy do not appear to offer any curative or symptom altering changes in the patient's condition. As a result, it is not supported as medically necessary.

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

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 7th day of March, 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.