



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

<b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address: Jason Fuller, D.C. 3724 Executive Center Drive, Suite G-10 Austin, Texas 78731	MDR Tracking No.: M5-06-1021-01 (current) M5-06-0437-01 (former)
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  Box 32	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: "Please reconsider the denied services between 10-29-04 and 3-11-05. The documentation provided in this report clearly demonstrates quantified objective documentation of effectiveness. The documentation clearly indicates the treatment relieved the effects of the injury with quantified and accepted questionnaires completed by the patient, objectively promoted recovery with routine and timely re-evaluations, enhanced the ability of the patient to return to work, enhanced the ability of the patient to return to normal ADL, and reduced the need for additional health-care services".

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

DOCUMENTATION SUBMITTED: 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)
10-29-04 to 03-11-05	97140-59 (\$66.02 X 8) = \$528.16	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2,351.65
	97140-59 (\$66.80 X 6) = \$400.80		
	97140-59 (\$33.40 X 3) = \$100.20		
	97110 (\$70.62 X 8) = \$564.96		
	97110 (\$105.93 X 3) = \$317.79		
	97110 (\$35.31 X 2) = \$70.62		
	97150 (\$17.57 X 2) = \$35.14		
	99211-25 (\$21.91 X 6) = \$131.46		
	99212-25 (\$26.96 X 3) = \$140.88		
	97014 (\$20.39 X 1) = \$20.39		
	G0283 (\$11.45 X 1) = \$11.45		
	97112 (\$29.80 X 1) = \$29.80		

#### 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.

**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 \$2,351.65. 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 \$650.00. 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:

02-08-06

\_\_\_\_\_  
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  
Amended: February 3, 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: M5-06-0437-01/M5-06-1021-01  
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 12.20.05.
- Faxed request for provider records made on 12.20.05.
- The case was assigned to a reviewer on 1.10.06.
- The reviewer rendered a determination on 1.26.06.
- The Notice of Determination was sent on 1.27.06.
- TDI DWC requested an amendment on 2.3.06.

The findings of the independent review are as follows:

#### Questions for Review

The therapy in question include manual therapy techniques (97140) (97140-59), therapeutic exercise (97110), group therapeutic activities (97150), office visits (99211) (99211-25) (99212-25), electrical stimulation (97014), electrical stimulation (G0283) and neuromuscular re-education (97112). The dates of service that are in dispute are from 10.29.04 to the date of 3.11.05.

#### 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 all of the eligible denied service(s).

#### Summary of Clinical History

The claimant was injured as a result of a work related injury on \_\_\_\_\_. The symptoms that the claimant suffered from include lower back pain and left lower extremity problems. Since the time of the injury, he claimant has received therapy, imaging and referrals.

#### Clinical Rationale

During the course of the therapy in question, the services provided clearly met numerous categories in regards to demonstrating patient improvement. The actual patient subjective complaints reduced, the VAS ratings reduced significantly, the need for medications reduced, provoking symptoms and other orthopedic findings reduced, frequency of symptoms reduced and all questionnaire studies reduced. Every category measured improved in a valid fashion and the claimant was released in a reasonable time frame from care for the given injury with an appropriate impairment rating. The claimant was also released back to work during treatment. The care was clearly beneficial for the patient, therefore the care was 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 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.

\_\_\_\_\_  
Meredith Thomas  
Administrator  
Parker Healthcare Management Organization, Inc.