



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                                 |                                 |
| Requestors Name and Address:<br>All Star Chiropractic & Rehab<br>8208 Bedford-Eules Road<br>North Richland Hills, Texas 76180 | MDR Tracking No.: M5-06-1040-01 |
|   | Claim No.:                      |
|   | Injured Employee's Name:        |
| Respondent's Name and Address:<br>Ace American Insurance Company<br>Box 15  | 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

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

No response received from Respondent

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS

| Date(s) of Service   | CPT Code(s) or Description                 | Medically Necessary?  | Additional Amount Due (if any) |
|----------------------|--|---|--------------------------------|
| 02-09-05             | 99214 < MAR                                | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$100.00                       |
| 02-09-05 to 04-12-05 | 97110 (4 units @ \$139.72 X 17 DOS)        | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$2,375.24                     |
| 02-09-05 to 04-12-05 | 97032 (1 unit @ \$19.81 X 17 DOS)          | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$336.77                       |
| 02-09-05 to 04-12-05 | 97140 (1 unit @ \$32.55 X 17 DOS) < MAR    | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$553.35                       |
| 03-22-05             | 97750-FC (16 units @ \$31.74 a unit) < MAR | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$507.84                       |
| 04-11-05 & 04-12-05  | 97545-WC (\$57.60 X 2 DOS)                 | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$115.20                       |
| 04-11-05 & 04-12-05  | 97546-WC (4 units @ \$115.20 X2 DOS)       | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$230.40                       |
| <b>TOTAL</b>         |  |   | \$4,218.80                     |

#### 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.

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 02-28-06, 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 99080-73 dates of service 02-25-05, 03-14-05, 04-12-05 and 04-26-05 were denied with denial code "V" (unnecessary treatment with peer review). Per Rule 129.5 the DWC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. Reimbursement is recommended in the amount of **\$60.00**.

CPT code 97545-WC dates of service 04-13-05 through 04-28-05 (11 DOS) were denied by the carrier with denial code "V" (unnecessary treatment with peer review). The services were preauthorized for 5 times per week for 2 weeks with preauthorization # ALLE04132005001. Per Rule 134.600(b) "the carrier is liable for all reasonable and necessary medical costs relating to the health care: preauthorization of any health care listed in subsection (h) of this section was approved prior to providing the health care". Reimbursement is recommended in the amount of **\$633.60 (\$57.60 X 11 DOS)** per Rule 133.301(a) and 134.202.

CPT code 97546-WC dates of service 04-13-05 through 04-28-05 (11 DOS) were denied by the carrier with denial code "V" (unnecessary treatment with peer review). The services were preauthorized for 5 times per week for 2 weeks with preauthorization # ALLE04132005001. Per Rule 134.600(b) "the carrier is liable for all reasonable and necessary medical costs relating to the health care: preauthorization of any health care listed in subsection (h) of this section was approved prior to providing the health care". Reimbursement is recommended in the amount of **\$1267.20 (\$115.20 X 11 DOS)** per Rule 133.301(a) and 134.202.

A Compliance and Practices referral will be made as the carrier is in violation of Rule 134.600.

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

28 Texas Administrative Code Sec. 133.308, 134.202 and 134.600 and 133.301(a)

**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 **\$6,179.60**. In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee (\$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:

04-26-06

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date of Findings and Decision

Order by:

04-26-06

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

April 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: M5-06-1040-01  
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 3.1.06.
- Faxed request for provider records made on 3.2.06.
- The case was assigned to a reviewer on 3.22.06.
- The reviewer rendered a determination on 4.6.06.
- The Notice of Determination was sent on 4.7.06.

The findings of the independent review are as follows:

### Questions for Review

Medical necessity of Office visit (99214), therapeutic exercises (97110), manual therapy (97140), work hardening (97545), work hardening each additional hour (97546), functional capacity examination (97750-FC) and electrical stimulation (97032) from 02.09.05 through 04.28.05.

### 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).

### Summary of Clinical History

The claimant underwent extensive physical medicine treatments and multiple surgeries after sustaining injury at work on \_\_\_\_.

### Clinical Rationale

Physical medicine is an accepted part of a rehabilitation program following surgery. Therefore, post-surgical treatment in the form of the office visit (99214), therapeutic exercises (97110), manual therapy (97140), functional capacity examination (97750-FC) and electrical stimulation (97032) were both indicated and medically necessary.

In regard to work hardening/conditioning (97545) and work hardening/conditioning each additional hour (97546), those treatments could have been reasonably expected to effect further gains. In fact, the provider was notified that these services were certified for medical necessity on April 18, 2005 by Patty Nagle, R.N. of Cambridge Integrated Services Group, Inc.

### Clinical Criteria, Utilization Guidelines or other material referenced

- Texas Labor Code 408.021

This conclusion is supported by the reviewers' clinical experience with over 8 years of patient care.

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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 7<sup>th</sup> day of April,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.