



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: Alameda Fitness & Rehab Center 3229 S. Alameda Street Corpus Christi, Texas 78404 | MDR Tracking No.: M5-06-1064-01 |
| | Claim No.: |
| | Injured Employee's Name: |
| Respondent's Name and Address: American Home Assurance Company C/o Flahive-Ogden-Latson Rep 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".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60
POSITION SUMMARY: None submitted

PART IV: SUMMARY OF DISPUTE AND FINDINGS

| Date(s) of Service | CPT Code(s) or Description | Medically Necessary? | Additional Amount Due (if any) |
|----------------------|--|---|--------------------------------|
| 09-07-05 to 10-17-05 | 97110-GP, G0283-GP, 97010-GP, 97113-GP, 97140-GP and 97002 | <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 disputed medical necessity issues.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308

PART VII: DIVISION DECISION

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 not entitled to reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

04-10-06

Authorized Signature

Date of Findings and Decision

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: M5-06-1064-01
RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 3.3.06.
- Faxed request for provider records made on 3.3.06.
- The case was assigned to a reviewer on 3.20.06.
- 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 therapeutic exercise (97110-GP), E-Stimulation (G0283-GP), hot/cold pack (97010-GP), aquatic therapy (97113-GP), manual therapy (97140-GP), and physical therapy re-evaluation (97002). Dates of service in dispute: 9.7.05-10.17.05

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 **uphold the denial** on the disputed service(s).

Summary of Clinical History

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

Clinical Rationale

While I respect the fact that the patient ultimately had a good outcome, due in no small part to the surgical, medical, and rehabilitation care he received. The duration of Physical Therapy care, specifically the passive treatments this patient received is excessive and the available documentation is not adequate enough to support it.

On 9/7, PT orders were received for "AAROM / AROM & HEP Emphasis". However, dates of service following 9/7 do not reflect the treating physician's guidelines for P.T. In fact, several dates of service after 9/7 continue to reflect a propensity of passive based treatments (hot pack, e-stim, manual therapy)

In the P.T. notes dated 9/26 the therapist's notes state "*the patient reports his R UE is stronger and more flexible...*" yet there are still billable units for hot packs & e-stim.

There is no indication that the therapy provided required the skills of a licensed Physical Therapist one on one. Rather, it appears that a repetitive program of passive treatments combined with some exercises was carried out day after day after day. There are no specific work-limiting criteria documented, only vague statements like "reduced range of motion, tenderness, and muscle spasms", which are not indicative of the need for skilled one on one Physical Therapy. There is simply not enough objective, functional-type documentation to support the need for this rehabilitation.

In summary, based on the above information it is my determination to uphold the denial of reimbursement set forth by the URA in the case of Mr. ____.

Clinical Criteria, Utilization Guidelines or other material referenced

This conclusion is supported by the reviewers' clinical experience as a Physical Therapist with over 6 years of experience and patient care.

The reviewer for this case is a Physical Therapist peer matched with the provider that rendered the care in dispute. The reviewer is engaged in the practice of physical therapy 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 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.

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.