



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: Rehab 2112 P O BOX 671342 Dallas, Texas 75267-1342	MDR Tracking No.: M5-06-1063-01 (previous MDR#) M5-06-1261-01 (new MDR #)
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: New Hampshire Insurance Company 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

POSITION SUMMARY: Per the table of disputed services "Services are medically necessary. Carrier did not pay WH charges according to our CARF accreditation".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60

POSITION SUMMARY: "Copy of peer rev attached showing Work Hardening not medically reasonable or necessary, program didn't meet Guidelines; no evidence the program was highly individualized, no notations provided that demonstrated job simulation Activities. Another reason is in the review".

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
02-15-05	97545-WH-CA (1 unit @ \$128.00 - \$102.40 payment)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$25.60
	97546-WH-CA (5 units @ \$320.00 - \$256.00 payment)		\$64.00
02-17-05 to 04-01-05	97545-WH-CA (1 unit @ \$128.00 X 16 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2,048.00
	97546-WH-CA (5 units @ \$320.00 X 13 DOS)		\$4,160.00
	97546-WH-CA (4 units @ \$256.00 X 2 DOS)		\$512.00
	97546-WH-CA-59-52 (3 units @ \$48.00 X 1 DOS)		\$48.00
	97546-WH-CA (2 units @ \$128.00 X 1 DOS)		\$128.00
	97546-WH-CA-59-52 (2 units @ \$32.00 X 1 DOS)		\$32.00
TOTAL			\$7,017.60

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 03-22-06, 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 97545-WH-CA (1 unit) date of service 02-21-05 was denied by the carrier with denial code "62" (payment denied/reduced for absence of, or exceeded, pre-certification/authorization. Procedure not approved by pre-authorization). Per advisory 2001-14 preauthorization for work hardening or work conditioning programs are not required for CARF accredited providers. Reimbursement recommended per Rule 134.202 in the amount of **\$128.00**.

CPT code 97546-WH-CA (5 units) date of service 02-21-05 was denied by the carrier with denial code "62" (payment denied/reduced for absence of, or exceeded, pre-certification/authorization. Procedure not approved by pre-authorization). Per Advisory 2001-14 preauthorization for work hardening or work conditioning programs are not required for CARF accredited providers. Reimbursement recommended per Rule 134.202 in the amount of **\$320.00**.

CPT code 97750-FC date of service 03-14-05 was denied with denial code "97" (payment is included in the allowance for another srvc/px. Included in global reimbursement. Reimbursement is being withheld as this procedure is considered integral to the primary proc billed). Per the 2002 Medical Fee Guideline code 97750-FC is not global to other services billed on the date of service in dispute. Reimbursement recommended in the amount of **\$296.00**.

CPT code 97545-WH-CA (1 unit) date of service 03-17-05 was denied for additional payment by the carrier and considered paid according to PPO contract. A payment of \$57.60 was made by the carrier. The carrier did not submit a copy of the contract. The Requestor submitted information that no contract existed. Additional reimbursement is recommended in the amount of **\$70.40**.

CPT code 97546-WH-CA (5 units) date of service 03-17-05 was denied for additional payment by the carrier and considered paid according to PPO contract. A payment of \$144.00 was made by the carrier. The carrier did not submit a copy of the contract. The Requestor submitted information that no contract existed. Additional reimbursement is recommended in the amount of **\$176.00**.

CPT code 97545-WH-CA (1 unit) date of service 03-30-05 was denied by the carrier due to a previous submission. Neither party submitted an original explanation of benefits so the review will be per Rule 134.202. Reimbursement is recommended in the amount of **\$128.00**.

CPT code 97546-WH-CA (2 units) date of service 03-30-05 was denied by the carrier due to a previous submission. Neither party submitted an original explanation of benefits so the review will be per Rule 134.202. Reimbursement is recommended in the amount of **\$128.00**.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.202, Advisory 2001-14

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 additional reimbursement in the amount of \$8,264.00. 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:

05-08-06

Authorized Signature

Date of Findings and Decision

Order by:

05-08-06

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.

May 1, 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: M5-06-1261-01
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 3.23.06.
- Faxed request for provider records made on 3.23.06.
- TDI-DWC issued an Order for payment on 4.3.06.
- The case was assigned to a reviewer on 4.10.06.
- The reviewer rendered a determination on 4.28.06.
- The Notice of Determination was sent on 5.1.06.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of work hardening (97545-WH-CA) and work hardening each additional hour (97546-WH-CA)

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 requested service(s).

Summary of Clinical History

The claimant was injured as a result of a work related MVA. Since the time of the accident, the claimant has received evaluations from multiple doctors and has received advanced imaging and diagnostics. There has been the application of various forms of passive, active and tertiary care.

Clinical Rationale

The claimant had a compensable and related injury with supportive findings on advanced imaging and examinations performed by multiple practitioners. The claimant initially could not perform in the necessary PDL. He had a lack of endurance and physical examination findings consistent with injury. The claimant does clearly have psychosocial issues such as depression, anxiety and other related psychosocial factors. The claimant also had reports of problems with activities of daily living. Given the complete picture of the given condition and related findings, there is clear necessity for a tertiary return to work program such as work hardening.

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

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 1st day of May, 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.