



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: Buena Vista Workskills 5445 La Sierra Drive # 204 Dallas, Texas 75231	MDR Tracking No.: M5-06-1572-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Zurich American Insurance Rep Box # 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

#### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

**DOCUMENTATION SUBMITTED:**

1. DWC-60/Table of Disputed Services
2. CMS 1500's
3. Explanation of Benefits

**POSITION SUMMARY:** "In summary, it is our position that Zurich has established an unfair and unreasonable time frame in paying for the services that were authorized and rendered to Ms. \_\_\_\_\_. Your help in resolving this case is appreciated".

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

**DOCUMENTATION SUBMITTED:** Response to DWC-60

**POSITION SUMMARY:** "Carrier asserts that the work hardening program is not healthcare reasonably required to treat the compensable injury based upon a carrier required medical exam performed by Dr. Willhoite in November 2005. In addition, the medical information submitted does not substantiate the need for the health care recommended. Therefore, the request was determined not to be medically necessary. SOAH decisions have held that documentation that is "too perfunctory to allow any reasonable assessment of the necessity for the care in question" does not meet relevant proof requirements. SOAH docket no. 453-02-053.M5".

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS (Medical Necessity Issues)

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
11-01-05 to 12-23-05	97545-WH-CA and 97546-WH-CA	<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.

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 05-26-06, the Medical Review Division submitted a Notice to the 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 97750 billed on date of service 11-21-05 was denied by the carrier with denial codes 151 (payment adjusted because the payer deems the information submitted does not support this many services) and 213 (the charge exceeds the scheduled value and/or parameters that would appear reasonable). The carrier has made a payment of \$71.25. Review of documentation submitted by the Requestor per Rule 133.307(g)(3)(A-F) revealed that the Requestor performed a Functional Capacity Evaluation, however, billed the Respondent for a Physical Performance Test. The Requestor was reimbursed the correct amount per Rule 134.202(c)(1) for a Physical Performance Test. Billing for a Functional Capacity Evaluation requires a modifier (FC). The Requestor did not bill appropriately for the service rendered, therefore, no additional reimbursement is recommended. A Compliance and Regulations referral will be made due to the Requestor billing with an improper code.

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

28 Texas Administrative Code Sec. 133.308, 133.307(g)(3)(A-F) and 134.202(c)(1)

**PART VII: DIVISION FINDINGS AND 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:

07-18-06

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

\_\_\_\_\_  
Typed Name

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

June 28, 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: M5-06-1572-01  
RE: Independent review for \_\_\_\_\_

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

- Parker Healthcare Management received notification of independent review on 5.26.06.
- Faxed request for provider records made on 5.26.06.
- The case was assigned to a reviewer on 6.14.06.
- The reviewer rendered a determination on 6.27.06.
- The Notice of Determination was sent on 6.28.06.

The findings of the independent review are as follows:

### Questions for Review

Medical necessity of a work hardening program from 11.1.05-12.23.05

### 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 requested service(s).

### Summary of Clinical History

This patient sustained a work-related injury to her left hand, wrist, and forearm on \_\_\_\_\_. She banged her wrist on the door of an industrial washing machine or the door slammed shut on her arm. She treated conservatively with the company doctor, Texas Med Clinic for about a month. Her left upper extremity was splinted during that time. She underwent a course of interventional pain procedures and ultimately had a surgical release and synovectomy on 07/06/2005.

She participated in a course of postoperative physical therapy and chiropractic treatment with Rita Sealy, D.C. She was referred to Buena Vista Work Skills a few weeks after surgery to assess injury-related mood disturbances and observable disturbances in mood and affect. She was identified as having a moderate to severe injury, related depression and anxiety as noted on Beck Anxiety Inventories and Beck Depression Indexes. Four sessions of outpatient individual psychotherapy were pre-authorized and delivered. She was prescribed Lexapro for depression and Elavil for sleep disturbances.

In November of 2005, Dr. Sealy prescribed a multi-disciplinary work-hardening program. A functional capacity evaluation was performed on 11/21/2005. The claimant was able to lift 2-1/2 pounds of weight. She was unable to push/pull weight. She was not able to do fine motor dexterity after 2 minutes. After attending the work-hardening program, the patient was re-evaluated on 12/23/2005. She demonstrated a maximum occasional lift of 2-1/2 pounds, which was documented in the team conference as no change since the 11/21/2005 FCE.

In terms of her psychological goals, it was noted that her average pain level is reduced. Her muscle tension is worse, her depression symptoms have increased and her anxiety symptoms have reduced. It is also noted on this team conference that the patient displayed considerable secondary gain. There appears to have been no improvement with her fear and avoidance techniques as noted throughout the daily documentation that she self limited her behavior and activity level secondary to pain.

## Clinical Rationale

In terms of this patient's progress in the work-hardening program, minimal if any progress is noted in either her functional capacities or psychological measures of improvement. The DWC Medical Guidelines state that patients must meet 4 criteria for a return to work program, including persons well likely to benefit from the program, persons whose current level of functioning interferes with their ability to carry out specific tasks required in the workplace, persons whose medical, psychological, or other conditions would not prohibit participation in the program, persons who are capable of attaining specific employment upon completion of the program.

After retrospectively reviewing the care rendered thus far, it would appear that she is not likely to benefit from a continuation of this program. The standard of medical necessity is that the treatment rendered must provide cure or relief of the effect of the injury, promote progress towards recovery, or enhance employability. The claimant was at a sedentary PDL when she entered the program and was at a sedentary PDL at this stage in the program. The standards for medical necessity are insufficiently supported. The records further substantiate that the dispute in services will fill the statutory requirements for medical necessity, since this patient did not obtain relief or promotion of recovery, and there was no enhancement of employability to return to or retain employment. The claimant's lack of response is documented by the provider's subjective findings and multiple recordings of no improvement.

## Clinical Criteria, Utilization Guidelines or other material referenced

- *Occupational Medicine Practice Guidelines*, Second Edition.
- *DWC Medical Guidelines*

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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, 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.

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 28<sup>th</sup> day of June, 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.