



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

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestors Name and Address:	MDR Tracking No.: M5-06-1679-01
Laredo Spine Medical Center, PA 6423 McPherson Rd., Suite 9 Laredo, Texas 78041	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
TX Mutual Insurance Company, Box 54	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position Summary: "... The care rendered to the patient has met criteria set by the Texas Labor Code section 408.21. Complete rationale for increased reimbursement can be found in the medical records of the complete medial dispute."

Principle Documentation:

1. DWC-60/Table of Disputed Services/Position Summary
2. CMS-1500's
3. EOBs

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position Summary: "... Texas Mutual requests that the request for dispute resolution filed be conducted under the provisions of the APA..."

Principle Documentation:

1. DWC-60 Response

PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
5-20-05 – 7-13-05	97035, 97140, 99213, 97110, G0283	<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
Texas Labor Code 413.031

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.

Findings and Decision by:

_____, Medical Dispute Officer

8-08-06

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.

July 26, 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: M5-06-1679-01
RE: Independent review for _____

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

- Parker Healthcare Management received notification of independent review on 6.9.06.
- Faxed request for provider records made on 6.9.06.
- TDI_DWC issued an Order for Payment on 6.21.06
- TDI_DWC issued an Order for Records on 6.29.06.
- The case was assigned to a reviewer on 7.12.06.
- The reviewer rendered a determination on 7.25.06.
- The Notice of Determination was sent on 7.26.06.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of 97035-ultrasound; 97140-manual therapy; 99213-office visit; 97110-therapeutic exercises and G0283- electrical stimulation during the dates of service 5.20.05 - 7.13.05.

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

The claimant was injured as a result of a work related accident in which she stepped off of a bus and felt pain in the area of the right knee. The claimant has had advanced imaging, orthopedic referrals and surgery. The surgery was performed on 3.16.05, approximately two months before the onset of the therapy in question.

Clinical Rationale

The progress notes provided for review do not demonstrate that the claimant made any significant progress over the course of care that is in dispute. The pain scales are not consistently marked and when they are, they show no signs of improvement. In fact, the claimant started out with pain levels at a 6 and finished on the last visit with a pain level of an 8. This is evidence that therapy made the claimant feel worse. There are no clear changes in range of motion or progress in regards to strength or motion. As a result, it is not clear if the extensive amount of therapy provided post surgically offered any benefit for the claimant. A reasonable amount of therapy post surgical, once released by the surgeon, would be 4 to 6 weeks. The first progress note that I have post surgical is listed as 4.25.05. As a result, care until the date 5.20.05 would be necessary, care beyond that time is not documented as having any significant impact on pain levels, range of motion or strength. There is no clear documentation that there was a curative or symptom relieving effect or return to gainful employment or promotion of recovery, as a result of therapy. As a result, therapy mentioned does not follow the criteria of medical necessity as listed by the labor code, 408.021.

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, 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 26th day of July, 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.