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

Requestors Name and Address:	MDR Tracking No.: M5-06-1780-01
Neuromuscular Institute of Texas – PA 9502 Computer Drive Suite 100 San Antonio, Texas 78229	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Liberty Insurance Corporation Rep Box # 28	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: Per the Table of Disputed Services "Services provided were based on pts needs as being medically necessary per treating dr's professional judgement."

Principle Documentation:

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

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: Per the Table of Disputed Services "Denied per peer review forty plus physical therapy chiropractic visits have been paid exceeding the recommendation of the peer reviews."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
06-14-05, 06-29-05 and 10-28-05	99212 ($45.00 X 3 DOS)	☒ Yes ☐ No	$135.00
10-03-05	99213 ($61.89 X 1 DOS)	☒ Yes ☐ No	$61.89
10-19-05 to 10-28-05	97035 (1 unit @ $14.63 X 5 DOS)	☒ Yes ☐ No	$73.15
10-19-05 to 10-28-05	97140-59 (1 unit @ $31.78 X 5 DOS)	☒ Yes ☐ No	$158.90
10-19-05 to 10-28-05	G0283 (1 unit @ $13.61 X 5 DOS)	☒ Yes ☐ No	$68.05
10-20-05, 10-24-05 and 10-27-05	98940 (1 unit @ $31.36 X 3 DOS)	☒ Yes ☐ No	$94.08
06-14-05 to 11-28-05	97110, 98940*, 99212*, 99080-73, 97035*, 97140-59*, G0283*, 99215 and A4649 (* with the exception of the DOS listed above)	☐ Yes ☒ No	$0.00
	TOTAL DUE		$591.07

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 **majority** of the disputed medical necessity issues.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.1 and 134.202(d)(2)
Texas Labor Code, Sec. 413.031 and 413.011 (a-d)

PART VII: DIVISION FINDINGS 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 $591.07. In addition, the Division finds that the Requestor was not the prevailing party and is not entitled to a refund of the IRO fee. The Division hereby **ORDERS** the Respondent 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.

Order by:

		09-29-06
Authorized Signature	Typed Name	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.

August 15, 2006
Amended: August 18, 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: M5-06-1780-01
RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 7.7.06.
- Faxed request for provider records made on 7.7.06.
- The case was assigned to a reviewer on 7.26.06.
- The reviewer rendered a determination on 8.14.06.
- The Notice of Determination was sent on 8.15.06.

The findings of the independent review are as follows:

Questions for Review

The therapy in question includes office visits (99212/99213/99215), therapeutic exercise (97110), chiropractic manipulative treatment (98940), special reports (99080-73), ultrasound (97035), manual therapy technique (97140-59), electrical stimulation (G0283) and surgical supply- misc (A4649). The dates of service are listed from 6.14.05 through the date of 11.28.05.

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 **uphold the denial** on all of the disputed service(s) that occurred from 6.14.05-10.18.05 and from 10.29.05-11.28.05, unless otherwise contradicted as being overturned. The denial will also be **upheld** on the disputed code surgical supply- misc (A4649).

The PHMO, Inc. physician reviewer has determined to **overturn the denial** on the disputed service(s): office visits (99212/99213), manipulative treatment (98940), ultrasound (97035), manual therapy technique (97140-59) and electrical stimulation (G0283) that were preformed between 10.19.05-10.28.05.
The denial is also **overturned** on the office visit codes (99212/99213) for dates of service 6.14.05, 6.29.05 and 10.3.05.

Summary of Clinical History

The claimant was injured as a result of a work related MVA. As a result the claimant has multiple injuries to multiple areas. The claimant has received conservative treatment and various other forms of care, diagnostics and therapy.

Clinical Rationale

The claimant on the dates of 10.19.05 through 10.28.05 was apparently receiving post injection therapy. Active care is reasonable and proven as effective during this time period. Repeating and administering passive care outside of the acute and sub-acute treatment periods is not supported. As a result, the care before the time period of the injections appears to be ineffective and offers no clear objective benefit for the claimant.

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 15th day of August, 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.