



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	
Requestor's Name and Address:	MDR Tracking No.: M5-06-1870-01
Edward Wolski, M. D. Wol+Med 2436 I 35 East, South Ste. #336 Denton, Texas 76205	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:
TASB RISK MGMT FUND, Box 47	

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position Summary: "We treated the compensable body area and used an appropriate diagnosis... The carrier is quoting a RME report from 12-20-04. However, this constitutes a prospective, rather than retrospective, review."

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 (Table of Disputed Services): "Medical necessity and compensability."

Principle Documentation:

1. DWC-60/Table of Disputed Services/Position Summary

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)
7-9-05 – 11-28-05	97035, 97110-59, 97530-59, 95851-59	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
Total Due			\$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 Respondent raised the issue of compensability. The PLN 11 which the Respondent submitted disputes degenerative changes and osteoarthritis. The diagnosis code which was listed on the CMS 1500's is 840.9-Sprain and strain unspecified site-shoulder and upper arm. This dispute has no compensability issues.

The Division has reviewed the enclosed IRO decision and determined that the Requestor did not prevail on the disputed medical necessity issues. No reimbursement recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

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

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

Findings and Decision by:

Medical Dispute Officer

11-15-06

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.

November 9, 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: M5-06-1870-01
RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 9.11.06.
- Faxed request for provider records made on 9.11.06.
- TDI-DWC issued an Order for Payment on 9.21.06.
- TDI-DWC issued an Order for Records on 10.4.06.
- The case was assigned to a reviewer on 10.30.06.
- The reviewer rendered a determination on 11.9.06.
- The Notice of Determination was sent on 11.9.06.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of 97035-ultrasound, 97110-59-therapeutic exercises, 97530-59- therapeutic activities, 95851-59- ROM. date of service in dispute: 7.9.05-11.28.05

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 the disputed service(s).

Summary of Clinical History

Ms. ____ is employed as a clerk for the _____ She is right-handed. She had ongoing complaints of moderate to severe pain in her right and her left shoulders as well as in her ankle.

Pertinent past medical history includes high blood pressure, diabetes, apparent thyroid problems since she is on Synthroid and migraine headaches. She had an FCE on December 10, 2004, which revealed a pain level of 7. She could not do some of the test because of high heart rate due to stressful situations. Her general aerobic fitness at that time was below average. Her shoulder function was described as fair. The left shoulder flexion was 90 degree, extension 25 degrees, internal rotation 90 degrees and abduction with 110 degrees. There was guarding of the neck and shoulders. Bending caused a pins and needles sensation to both shoulders.

She began a very prolonged period of physical therapy to include hydrocollator therapy, activities of daily living, ultrasound, hydrocortisone, aqua sonic gel, therapeutic exercises, and therapeutic activities on a one-on-one situation.

Clinical Rationale

It is felt the items in dispute were not medically necessary as indicated by the lack of any improvement in the patient's condition over the period of time. Strength was increased slightly; however, most of these modalities could be well performed at home. A major problem here seems to be that of the diagnoses. Before Ms. ___ is considered for further therapy for her right shoulder, it is recommended that she be referred to a neurologist or neurosurgeon to determine whether her shoulder problems are due to any neck problems, cervical spine problems; or perhaps she may have problems with her lumbar spine causing the leg problems, especially since this was a fall on her back. Of course, this conclusion is based on the medical records made available to us.

Due to the lack of improvement continued care was unwarranted, therefore the denial is upheld on the disputed services as medical necessity could not be established.

Clinical Criteria, Utilization Guidelines or other material referenced

Occupation Medicine Practice Guidelines, 2nd Edition of the American College of Occupational Environmental Medicine, page 196, Chapter 9

The reviewer for this case is a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Occupational and Preventive medicine, and is engaged in the practice of medicine.

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 9th day of November, 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.