



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	
Requestor's Name and Address: Buena Vista Workskills 5445 La Sierra Drive # 204 Dallas, Texas 75231-3444	MDR Tracking No.: M5-07-0191-01 (current tracking number) M5-06-1145-01 (former tracking number)
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Continental Casualty Company Rep Box # 47	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: "In summary, it is our position that CNA has established an unfair and unreasonable time frame in paying for the services that were rendered to Ms. ____."

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: "It is also the carrier's position that the services provided were not medically necessary, pursuant to a peer review performed by Dr. Casey Cochran on November 22, 2005, attached to this response."

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)
10-24-05 to 11-30-05	97545-WH-CA (1 unit @ \$128.00 X 22 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2,816.00
10-24-05 to 11-30-05 except for DOS 10-26-05, 10-27-05, 10-31-05 and 11-21-05	97546-WH-CA (1 unit @ \$64.00 X 6 units X 18 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$6,912.00
10-26-05, 10-31-05 and 11-21-05	97546-WH-CA (1 unit @ \$64.00 X 5.75 units X 3 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,104.00
10-27-05	97546-WH-CA (1 unit @ \$64.00 X 4.25 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$272.00
TOTAL DUE			\$11,104.00

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 prevail** on 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(e)(5)(C)(i)(ii)
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 \$11,104.00. In addition, the Division finds that the Requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of \$460.00. 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.

Findings and Decision by:

01-09-07

Authorized Signature

Typed Name

Date of Findings and Decision

Order by:

01-09-07

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.

December 8, 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: M5-07-0191-01
RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 11.1.06.
- Faxed request for provider records made on 11.1.06.
- The case was assigned to a reviewer on 11.15.06.
- The reviewer rendered a determination on 12.7.06.
- The Notice of Determination was sent on 12.8.06.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of 97545-WH-CA-Work Hardening, 97546-WH-CA-Work Hardening. The dates of service are listed as 10.24.05 - 11.30.05.

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 **overturn the denial** on the all of the disputed service(s).

Summary of Clinical History

The claimant was injured as a result of a work related injury on _____. The injury occurred due to the claimant falling and landing on her hands and knees. She was sent to the company doctor and eventually made an attempt to return back to work which failed due to excessive pain. Since the injury she has received injections and several surgeries. She has changed doctors and has received behavioral health intervention. She has mental health diagnoses such as pain disorders with psychological factors, panic disorder with agoraphobia, major depressive disorder and a GAF score of 55. The BDI-II indicated depression and the BAI indicates severe anxiety. Electrodiagnostics demonstrated right cubital tunnel syndrome and bilateral median nerve abnormalities. Since the accident, she has been prescribed pain medication and medication for her psychological status. On 6.9.06 the claimant was not put at MMI by a designated doctor. Functional studies and physical examination demonstrated that the claimant had functional and range of motion loss as well as inadequacies as it related to specific function.

Clinical Rationale

The claimant had multiple compensable injuries, multiple surgeries and failed physical therapy before entering tertiary care. The claimant had a psychological diagnosis, BDI-II and BAI and GAF scores that were significant. Functional studies and physical examination demonstrated functional loss. The claimant had attempted to return back to work but could not due to pain and functional inadequacies. The claimant had to be medicated to control pain with narcotics and had to take medication for psychological stability. The claimant meets the criteria for tertiary care. There was a mental/psychological component, there was functional loss, previous care had failed, previous attempts to return to work failed, she was post surgical and she initially fit the profile of a patient that could benefit from tertiary vocational care 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

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 8th day of December, 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.