



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: Tommy Overman, ED.D/Russell Blaylock, OTR 6161 Harry Hines Boulevard, Suite 105 Dallas, Texas 75235	MDR Tracking No.: M5-07-0342-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Insurance Company Rep Box # 54	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 "Work hardening was necessary – letter explained in recon. Insurance just denied stating duplicate after recon."

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: The position statement submitted by Texas Mutual does not address the disputed services.

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)
01-23-06 to 02-03-06	97545-WH-CA (1 unit @ \$128.00 X 10 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,280.00
01-23-06 & 01-31-06	97546-WH-CA (1 unit @ \$64.00 X 3 units X 2 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$384.00
01-24-06, 01-25-06, 01-26-06, 01-30-06, 02-01-06 and 02-02-06	97546-WH-CA (1 unit @ \$64.00 X 6 units X 6 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2,304.00
01-27-06	97546-WH-CA (1 unit @ \$64.00 X 4 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$256.00
02-03-06	97546-WH-CA (1 unit @ \$128.00)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$128.00
TOTAL DUE			\$4,352.00

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, 134.202(e)(5)(A)(1) and 134.202(e)(5)(C)(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 \$4,352.00. 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 \$650.00. 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 Order by:

Authorized Signature

Typed Name

02-27-07

Date of Findings and 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.

February 7, 2007
Amended: February 12, 2007

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: M5-07-0342-01
RE: Independent review for _____

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

- Parker Healthcare Management received notification of independent review on 12.27.06.
- Faxed request for provider records made on 12.27.06.
- TDI DWC issued an Order for records on 1.9.07.
- The case was assigned to a reviewer on 1.25.07.
- The reviewer rendered a determination on 2.6.07.
- The Notice of Determination was sent on 2.7.07.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of Work Hardening (97545-WH-CA), Work Hardening each addt'l hour (97546-WH-CA). Dates in dispute: 1.23.06-2.3.06

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 denied service(s).

Summary of Clinical History

This individual was injured while working on traffic signs when a traffic light bucket struck him in the back of the head and knocked him into a hole. He was knocked unconscious. He was struck in the back in the thoracic spine and sustained the injury. He was treated by Dr. Charles Mitchell, an orthopedic surgeon, who performed an arthroscopy and partial meniscectomy of the left knee. He continued to have pain and was started on a pain management program at Dallas Spinal Rehab.

Clinical Rationale

It was decided that at completion of pain management, he should participate in a work-hardening program because he was functioning at the light demand level. And while he did not have a specific job to return to, he was a manual laborer and typical manual laborer would have to be at least medium to heavy. He received a two-week work-hardening program and he improved by one level of physical demand capabilities. I believe it was reasonable and appropriate to treat an individual to try to help them reach their maximum functional level, especially when they are significantly lower than their present functional level.

The role of the IRO physician is not just to regurgitate the official disability guidelines, but to apply experience and practice to decisions as to what is best in healthcare based on reasonable medical probability. It is my opinion, based on reasonably medical probability, with much experience in treating these patients and the facts reflected in these notes that this individual did improve by one demand level in just a two-week time. The treatment was reasonable, appropriate, and directly related to the work injury.

The carrier's denial is overturned for the reasons stated above. Now, the state can benefit from the fact that this individual has a much greater chance of finding employment working at a higher level despite the fact that he still has pain.

Clinical Criteria, Utilization Guidelines or other material referenced

This conclusion is supported by the reviewers' clinical experience with over 10 years of patient care.

The reviewer for this case is a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical medicine and Rehabilitation, and is engaged in the full time 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 7th day of February, 2007. 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.