



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

|   |                                 |
|---|---------------------------------|
| <b>Type of Requestor:</b> ( X ) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier                       |                                 |
| Requestor's Name and Address:<br>North Texas Pain Recovery Center<br>6702 W. Poly Webb Road<br>Arlington, Texas 76016 | MDR Tracking No.: M5-07-0385-01 |
|   | Claim No.:                      |
|   | Injured Employee's Name:        |
| Respondent's Name and Address:<br>Liberty Insurance Corporation<br>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 "Medical Necessity."

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 Respondent did not submit a position summary to MDR.

Principle Documentation: The Respondent did not submit a response to MDR.

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS

| Date(s) of Service   | CPT Code(s) or Description                       | Medically Necessary?  | Additional Amount Due (if any) |
|----------------------|--|---|--------------------------------|
| 06-26-06 to 06-30-06 | 97545-WH-CA (1 unit @ \$128.00 X 5 DOS)          | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$640.00                       |
| 06-26-06 to 06-30-06 | 97546-WH-CA (1 unit @ \$64.00 X 6 units X 5 DOS) | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$1,920.00                     |
| <b>TOTAL DUE</b>     |  |   | \$2,560.00                     |

#### 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 and 134.202(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 \$2,560.00. 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 Order by:

03-20-07

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Typed Name

\_\_\_\_\_  
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 22, 2006  
Amended: March 8, 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: M5-07-0385-01  
RE: Independent review for \_\_\_\_\_,

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

- Parker Healthcare Management received notification of independent review on 1.10.07.
- Faxed request for provider records made on 1.10.07.
- The case was assigned to a reviewer on 1.29.07.
- The reviewer rendered a determination on 2.21.07.
- The Notice of Determination was sent on 2.22.07.

The findings of the independent review are as follows:

### Questions for Review

Medical necessity of work hardening (97545-WH-CA) and work hardening each additional hour (97546-WH-CA). The dates of service listed in dispute are from 6-26-06 to 6-30-06.

### 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 items in dispute.

### Summary of Clinical History

The claimant was injured as a result of a work related injury. The injury was sustained while working for \_\_\_\_\_. The claimant struck their knee against an object, thus sustaining an injury to the knee. Since the time of the accident, the claimant has received diagnostics, referrals, various forms of treatment and therapy.

### Clinical Rationale

The patient clearly had the medical need for tertiary work hardening care. The MFG guidelines, CARF guidelines and Texas Labor Code clearly demonstrate necessity in this case. At the time of admission to the program the patient had inadequate lifting capability, psychological findings and functional loss that all equaled an overall inability to produce in her particular vocational environment. When reviewing the documentation that reflects outcomes, the patient improved each week that they were present in work hardening. The first week they demonstrated above 100% improvement in lifting and demonstrated psychological improvements based upon Beck's, DPQ and analog pain scale. The second week the patient did not demonstrate as dramatic as improvement; however, still clearly progressed both physically and mentally. The third week was similar. The patient demonstrated consistent and significant improvement during all three weeks of care provided. As a result of the consistent improvement, care was established as effective and medically necessary.

## Clinical Criteria, Utilization Guidelines or other material referenced

*Occupational Medicine Practice Guidelines*, Second Edition.

CARF Guidelines

Texas Labor Code

*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 22<sup>nd</sup> 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.

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Meredith Thomas  
Administrator  
Parker Healthcare Management Organization, Inc.