



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: San Antonio Accident/Injury Care 401 W. Commerce, Suite 100 San Antonio, Texas 78207	MDR Tracking No.: M5-07-0442-01 (current MDR #) M4-05-8127-01 (former MDR #)
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  Rep Box # 29	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 "Treatment given to patient was medically necessary."

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 the position of the Carrier that the treatment made the basis of this dispute was not reasonable or necessary for the injury made the basis of the claim."

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)
10-13-04 to 11-11-04	97116-GP (1 unit @ \$29.50 X 8 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$236.00
10-13-04 to 11-11-04	97112-GP (1 unit @ \$34.30 X 8 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$274.40
10-13-04 to 11-11-04	97530 (1 unit @ \$34.65 X 6 units X 7 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,455.30
<b>TOTAL DUE</b>			\$1,965.70

#### 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(c)(1)  
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 \$1,965.70. 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:

03-09-07

\_\_\_\_\_  
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 16, 2007  
Amended: February 27, 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: M5-07-0442-01  
RE: Independent review for \_\_\_\_\_

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

- Parker Healthcare Management received notification of independent review on 1.4.07
- Faxed request for provider records made on 1.4.07.
- The case was assigned to a reviewer on 1.24.07.
- The reviewer rendered a determination on 2.15.07.
- The Notice of Determination was sent on 2.16.07.

The findings of the independent review are as follows:

### Questions for Review

Medical necessity of 97116-GP-Gait training, 97112-GP-Neuromuscular re-education, 97530-therapeutic activities for the dates of service 10.13.04-11.11.04.

### 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 all of the disputed service(s).

### Summary of Clinical History

The claimant was injured as a result of a work related injury on the date of \_\_\_\_\_. The accident occurred when she was restraining a student while at work. While she was doing this she tripped and sustained injury. Since the injury she has received an injection, conservative care, medicinal care, diagnostics and various referrals.

### Clinical Rationale

The claimant had a documented injury that involved a fracture, disc pathology, neurological symptoms and chronic pain with functional deficit. It is understood with injuries of this type that prolonged and slow recovery can at time be expected. The claimant participated in a period of active that started in early July of 2004. It was documented as having little impact after that brief period. As a result, there was a change in the treatment protocol. Epidural steroid injections were initiated on the date of 9-7-04, which was when the first injection was administered. During this time and the injection in conjunction with continued active care reduced the claimants tingling reduced 40% and weakness reduced 25% and improvement in range of motion was noted. It is a typical and accepted protocol to continue with a series of further injections if the first is successful and it is encouraged to promote and provide active care in conjunction with epidural injection therapy. During the time period of care that is being denied is when the claimant really started to improve. As a result of the aforementioned care provided, the claimant was ultimately capable of reaching MMI in November of 2004.

### Clinical Criteria, Utilization Guidelines or other material referenced

*Occupational Medicine Practice Guidelines, Second Edition.*

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 16<sup>th</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.