



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: Rehab 2112 P O BOX 671342 Dallas, Texas 75267-1342	MDR Tracking No.: M5-07-0571-01 (current MDR #) M4-05-6937-01 (former MDR #)
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Zurich American Insurance Company Rep Box # 19	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 "Carrier violated Rule 133.304(a) as the carrier has failed to take final action on these medical bills. The bills have been submitted to the carrier a total of 3 times. The carrier's customer service department has no record of these bills. See attached certified mail receipts showing proof that the carrier received these bills."

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: "Attached is the completed TWCC-60. Carrier does not currently have access to the missing EOBs in this dispute. Carrier will supplement as soon as the EOBs are located for any of the dates of service in dispute."

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?	Amount Due
06-10-04	97110 (1 unit @ \$35.69 X 3 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$107.07
10-11-04	97110 (1 unit @ \$35.69 X 2 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$71.38
10-15-04	97110 (1 unit @ \$35.69 X 4 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$142.76
06-10-04, 06-25-04, 06-29-04 and 07-02-04	97140 (1 unit @ \$32.90 X 4 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$131.60
06-25-04, 06-29-04, 07-02-04, 07-05-04	97113 (1 unit @ \$35.69 X 3 units X 4 DOS)(see note below)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$428.28
10-13-04	97113 (1 unit @ \$35.69 X 4 units)(see note below)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$142.76
10-11-04	99213 (see note below)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$44.11
11-01-04 to 11-16-04	97545-WH-CA (1 unit @ \$128.00 X 9 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,152.00

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Amount Due
11-01-04, 11-02-04, 11-03-04, 11-08-04 and 11-12-04	97546-WH-CA (1 unit @ \$64.00 X 5 hours X 5 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,600.00
11-09-04, 11-10-04, 11-11-04 and 11-16-04	97546-WH-CA (1 unit @ \$64.00 X 4 hours X 4 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,024.00
11-09-04, 11-10-04 and 11-11-04	97546-WH-CA-59-52 (3 increments @ \$48.00 X 3 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$144.00
11-16-04	97546-WH-CA-59-52 (4 increments @ \$64.00)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$64.00
11-17-04	97750-FC (1 unit @ \$35.66 X 8 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$285.28
	NOTE: Requestor did not bill MAR		
	TOTAL DUE		\$5,337.24

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
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 \$5,337.24. 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:

03-23-07

Authorized Signature

Typed Name

Date of Findings and Decision

Order by:

03-23-07

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.

March 1, 2007
Amended: March 5, 2007
Amended: March 20, 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: M5-07-0571-01
RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 1.12.07.
- Faxed request for provider records made on 1.12.07.
- TDI-DWC issued an Order for payment on 1.24.07.
- The case was assigned to a reviewer on 2.8.07.
- The reviewer rendered a determination on 2.28.07.
- The Notice of Determination was sent on 3.1.07.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of services in dispute to include: therapeutic exercise (97110), manual therapy technique (97140), aquatic therapy (97113), office visits (99213), work hardening (97545-WH-CA), work hardening each additional hour (97546-WH-CA) and functional capacity evaluation (97750-FC). The dates of service are listed as 6.10.04 thru 11.17.04.

Determination

PHMO, Inc. has performed an independent review of the disputed 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 at work while lifting boxes while on a ladder. As a result of losing her balance, she started to struggle to regain it and injured her right shoulder. Surgery was performed on 5.24.04 to the right shoulder. Functional capacity studies were done on the dates of 10.25.04 and 11.17.04.

Clinical Rationale

The patient had shoulder surgery on the date of _____. The patient did post surgical treatment starting on the date of 6.10.04. It appears that post-surgical care is being disputed. Post surgical rehabilitation is necessary and customary. Post surgical therapeutic exercise, manual therapy, aquatic therapy and supportive office visits are all supported post surgically and are considered customary after surgery. After this form of care, function status had to be measured to determine if the claimant could or could not return back to work. There is really only one way to do this accurately and objectively and that is by functional testing. The initial and the interim FCE's were necessary to determine functionality and provide outcome assessment. The patient clearly did not match their required PDL. As a result, the need for a brief period of tertiary care such

as work hardening was established. The claimant got better during care and the final FCE determined improvement and the claimant was dismissed back to work. The post surgical care, functional studies and tertiary return to work services were all supported, medically necessary and provided a successful outcome for the claimant.

Clinical Criteria, Utilization Guidelines or other material referenced

Occupational Medicine Practice Guidelines, Second Edition.

The Medical Disability Advisor, Presley Reed MD

A Doctors Guide to Record Keeping, Utilization Management and Review, Gregg Fisher

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 1st day of March, 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.