



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

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address: Anthony Jones DC 201 East Main St Richardson TX 75080	MDR Tracking No.: M5-05-2350-01
	Claim No.:
	Injured Worker's Name:
Respondent's Name and Address: Hartford Fire Insurance Box 27	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documentation submitted: TWCC-60 package, EOBs, CMS-1500s
 Position summary: Claimant entitled to all health care for compensable injury per Texas labor Code 408.021. Medical to support medical necessity will be sent to IRO upon request.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documentation submitted: None
 Position summary from Table of Disputed Services: Peer review indicates documentation does not support the treatment to be medically unreasonable and/or necessary.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
9-27-04 to 3-9-05	99201, 99213, 97032, 97110, 97112, 97530, 97139, 97799	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$ 0.00
		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

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 **not** prevail on the disputed medical necessity issues.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.202

PART VII: DIVISION DECISION

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 not entitled to additional reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

Dee Z. Torres, Medical Dispute Officer

9-29-05

Authorized Signature

Typed Name

Date

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.

IRO America Inc.

An Independent Review Organization

7626 Parkview Circle

Austin, TX 78731

Phone: 512-346-5040

Fax: 512-692-2924

September 20, 2005

TWCC Medical Dispute Resolution

Fax: (512) 804-4868

Patient: _____
TWCC #: _____
MDR Tracking #: M5-05-2350-01
IRO #: 5251

IRO America Inc. (IRO America) has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission (TWCC) has assigned this case to IRO America for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

IRO America has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor; the Reviewer is a credentialed Panel Member of IRO America's Medical Knowledge Panel who is a licensed Provider, board certified and specialized in Chiropractic Care. The reviewer is on the TWCC Approved Doctor List (ADL).

The IRO America Panel Member/Reviewer is a health care professional who has signed a certification statement stating that no known conflicts of interest exist between the Reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to IRO America for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

RECORDS REVIEWED

Notification of IRO assignment, information provided by Requestor, Respondent, and Treating Doctor(s) including: EOB's, peer review from Michael Hamby DC, notes from Michael Taba MD, MRI of Right Shoulder, treatment notes from Healing Hands Chiropractic, operative report from Michael Taba MD, IME from Michael Ciepiela MD, notes from William Hester PhD.

CLINICAL HISTORY

This patient stated she had a work related injury on _____. While working on a computer, she began to feel pain in the neck, right shoulder, right arm and wrist. She has not worked since the date of injury.

DISPUTED SERVICE(S)

Under dispute is retrospective medical necessity of office visits 99201/99213, electric stimulation (manual) – 97032, therapeutic exercises -97110, neuromuscular re-education 97112, therapeutic activities 97530, unlisted therapeutic procedures 97139, and unlisted physical medicine 97799 for dates of service 9/27/2004 through 3/9/2005.

DETERMINATION/DECISION

The Reviewer agrees with the determination of the insurance carrier.

RATIONALE/BASIS FOR THE DECISION

The date of injury for this patient is ____, and appears to have been under treatment for seven (7) months prior to reaching the dates of dispute. Therefore the 99201, a new patient exam code, cannot be valid since treatment was initiated in March of 2004. Passive therapies such as electric stimulation are not reasonable at this point in care as outlined in the *Texas Workers' Compensation Commission Upper Extremity Guideline §134.1003* and the *Texas Guideline for Chiropractic Quality Assurance and Practice Parameters*. A MRI was finally performed on January 17, 2005, nearly one year post injury and revealed a partial tear of the right supraspinatous tendon. This finding does not correlate with the history of the injury but none the less should have been diagnosed at a much earlier date with the lack of progress and continued patient complaints. All of the active rehab was performed prior to the surgery which could have exacerbated the injury and caused more tissue damage. In fact, within the six months of rehab, there should have been indicators to suggest this patient should have been evaluated more closely to prevent unreasonable and over utilized care. After the surgery, a post surgical rehab and an active rehab program would be necessary to return the patient to a pre-injury status but would be redundant to the treatment rendered prior to surgery.

Screening Criteria

1. Specific:

Texas Workers' Compensation Commission Upper Extremity Guideline §134.1003
Texas Guideline for Chiropractic Quality Assurance and Practice Parameters

2. General:

In making his determination, the Reviewer had reviewed medically acceptable screening criteria relevant to the case, which may include but is not limited to any of the following: Evidence Based Medicine Guidelines (Helsinki, Finland); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Texas Chiropractic Association: Texas Guidelines to Quality Assurance (Austin Texas); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Mercy Center Guidelines of Quality Assurance; any and all guidelines issued by TWCC or other State of Texas Agencies; standards contained in Medicare Coverage Database; ACOEM Guidelines; peer-reviewed literate and scientific studies that meet nationally recognized standards; standard references compendia; and findings; studies conducted under the auspices of federal government agencies and research institutes; the findings of any national board recognized by the National Institutes of Health; peer reviewed abstracts submitted for presentation at major medical associates meetings; any other recognized authorities and systems of evaluation that are relevant.

CERTIFICATION BY OFFICER

IRO America has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. IRO America has made no determinations regarding benefits available under the injured employee's policy.

As an officer of IRO America Inc., I certify that there is no known conflict between the Reviewer, IRO America and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

IRO America is forwarding by mail or facsimile, a copy of this finding to the TWCC, the Injured Employee, the Respondent, the Requestor, and the Treating Doctor.

Sincerely,

IRO America Inc.



Dr. Roger Glenn Brown

President & Chief Resolutions Officer