



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 and Fee Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address: ACTIVE REHAB ASSOCIATES, PA DBA TEXAS WORKERS REHAB OF DALLAS 9400 N MCAUTHER BLVD SUITE 124-621 IRVING TX 75063	MDR Tracking No.: M5-05-2736-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: DALLAS FIRE INS C/O DOWNS – STANFORD PC BOX 17	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documentation provided included TWCC-60, explanation of benefits and CMS 1500s. Requestor states that services are medically necessary.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent states that claimant has had extensive chiropractic treatments, physical therapy, and medications since his injury of _____. Respondent further states that the requestor failed to provide any documentation to support the medical necessity of the work hardening.

PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Amount Due (if any)
06-10-04 to 08-11-04	97545-WH-CA \$128.00 x 17 DOS = \$2,176.00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$8,240.00
	97546-WH-CA \$128.00 x 1 DOS = \$ 128.00		
	97546-WH-CA \$320.00 X 2 DOS = \$640.00		
	97546-WH-CA \$384.00 X 12 DOS = \$4,608.00		
	97546-WH-CA \$352.00 X 1 DOS = \$ 352.00		
	97546-WH-CA \$336.00 x 1 DOS = \$336.00		

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. The amount due the requestor for the items denied for medical necessity is \$8,240.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, and 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 entitled to reimbursement in the amount of \$8,240.00. 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 insurance carrier to remit these amounts 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:

	Medical Dispute	9-20-05
Authorized Signature	Officer Typed Name	Date

Order by:	Manager, Medical Necessity Team, Medical Review Division	9-20-05
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

(IRO America Inc. was formerly known as ZRC Services Inc. DBA ZiroC)

**7626 Parkview Circle
Austin, TX 78731
Phone: 512-346-5040
Fax: 512-692-2924**

August 23, 2005

TWCC Medical Dispute Resolution
Fax: (512) 804-4868

Patient: _____
TWCC #: _____
MDR Tracking #: M5-05-2736-01
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: letter of representation from Downs. Stafford PC, group therapy notes from Buddy Duncan & Associates, notes from Dr Stephen Orwig, FCE from Dallas Medical Services, notes from Metroplex Orthopedics, assessment (RME) by Hooman Sedighi MD, designated doctor evaluation from William Jones MD, MRI of the Thoracic and Lumbar Spine, Lumbar Myelogram, CT Lumbar Spine, lower extremity NCV/EMG.

CLINICAL HISTORY

The patient, Mr. ___ who was 21years of age at the time of the injury, stated he was injured on ___, while performing his duties as a general packer for _____. The patient stated he was hit by a co-worker from behind with a forklift, causing him to hit a wall, subsequently injuring his low back.

DISPUTED SERVICE (S)

Under dispute is the retrospective medical necessity of work hardening program 97545-WH-CA and 97546-WH-CA from 6/10/2004 to 8-11-2004.

DETERMINATION / DECISION

The Reviewer disagrees with the determination of the insurance carrier in this case.

RATIONALE / BASIS FOR DECISION

Work hardening this far post injury would not be considered reasonable and necessary for a conservative level of treatment. However, given the findings of the diagnostic studies and the failed conservative treatment, surgical intervention was required. In light of this procedure, and the amount of time taken for completion of a post surgical rehab program (i.e. pain free isometric exercises), the next step would be to progress this patient from active rehab into a work hardening program to prevent future injury. This follows an acceptable treatment protocol with the *Texas Workers' Compensation Commission Spinal Treatment Guideline §134.1001* and the *Texas Guidelines for Quality Assurance and Practice Parameters*.

Screening Criteria

1. Specific

Texas Workers' Compensation Commission Spinal Treatment Guideline §134.1001
Texas Guidelines for 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 literature 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