



Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

CORRECTED 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: Injury One Treatment Center 5445 La Sierra Drive Suite 204 Dallas TX 75231	MDR Tracking No.: M5-05-2877-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Travelers Indemnity Box 5	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Letter dated 6-27-05 states in part, "... Traveler's Indemnity Insurance has denied this patient's claims. The original EOB was denied because of unnecessary treatment per RME, when reconsideration was completed the claims were denied stating 'denial after reconsideration.' This patient's recovery would have been negatively impacted without these treatments... [injured worked] attended the work hardening program, Injury One Treatment Center is a CARF accredited facility and payment is reimbursed at 100%.... Traveler's Ins. Has paid for all other work hardening dates of service excluding these..."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Letter dated 7-13-05 states in part, "... We are sustaining the denial of all dates of service in question based on the RME performed by Dr. Brett J. Bolte, M.D. on January 14, 2005 and on the Peer Review performed by Dr Philip Lening, D.C. on June 25, 2004..."

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
1-19-05 to 3-8-05	97545-WH-CA, 97546-WH-CA	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
1-19-05 to 3-8-05	97750-FC	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
1-19-05 to 3-8-05	99070	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
		<input type="checkbox"/> Yes <input 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.

This CORRECTED Findings and Decision supercedes the previous Decision rendered in this medical payment dispute involving the above 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. Therefore, no reimbursement is due from the carrier.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 134.202

PART VII: CORRECTED 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 reimbursement and is not entitled to a refund of the paid IRO fee.

Corrected Findings and Decision by:

11-18-05

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 CORRECTED 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

September 7, 2005

TWCC Medical Dispute Resolution

Fax: (512) 804-4868

Patient: _____

TWCC #: _____

MDR Tracking #: M5-05-2877-01

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:

1. Records from Waco Ortho Rehab dated 06/04/03 through 08/20/03
2. Initial evaluation from Waco Ortho Rehab dated 06/04/03
3. Followup notes from Waco Ortho Rehab dated 06/27/03 and 08/19/03
4. Initial evaluation from Robert Allred, M.D., dated 06/10/04
5. Followup notes by Robert Allred, M.D., dated 09/08/04 through 10/06/04
6. Operative report from Metroplex Hospital dated 08/13/04
7. Impairment rating from Churchill Evaluation Center dated 04/07/05, Robert Hilliard, M.D., 1% whole person impairment rating
8. Peer review from Philip Lening, D.C., dated 06/25/04
9. An RME from Optima Medical Group dated 01/14/05, Brett Bolte, M.D.
10. Waco Radiology MRI scan report, right knee and lumbar spine, dated 05/28/04
11. Ortho Spine Clinic designated doctor evaluation, Peter Foon, M.D., 02/12/04, 5% whole person impairment rating
12. Injury One Treatment Center behavioral consultation dated 12/28/04, Tatia Miller, LA, LPC and Phil Bohart, MS, LPC
13. Letter of medical necessity from Allied Multicare Centers dated 03/16/05, Michael Moordecai, D.C.
14. FCE dated 02/17/05 and a final FCE dated 03/08/05 from Injury One Treatment Center
15. Records from Allied Multicare Centers

CLINICAL HISTORY

The patient was injured on the job on _____. The patient was working for _____: unloading stock when he was struck on the right knee, injuring his right knee and lumbar spine. He initially presented to Waco Ortho Rehab on 06/04/03 and was evaluated by Darcy Pope, D.C. Initial diagnosis included grade 2 sprain/strain of the right knee, spasm of the muscle, lumbar sprain/strain grade 2, and lumbar facet syndrome. A course of chiropractic treatment/physical rehabilitation was initiated at Waco Ortho Rehab beginning on 06/04/03. The patient was seen for a total of 38 visits including extensive therapy and rehabilitation at Waco Ortho Rehab. He then changed treating doctors to Allied Multicare Centers, at which time a repeat MRI scan was ordered of the lumbar spine and right knee. Further consultation was obtained with Robert Allred, M.D. on 06/10/04. Dr. Allred's impression was of a symptomatic anterior cruciate deficiency of the right knee. He recommended ACL reconstruction. Operative intervention was performed by Dr. Allred on 08/13/04 to include a reconstruction of the anterior cruciate ligament and repair of the posterior horn of the medial meniscus of the right knee. Postoperative physical therapy was performed at Allied Multicare Centers under the guidance of Michael Mordecai, D.C. Subsequent to completion of the postoperative physical therapy, the patient was placed into a work hardening program at Injury One Treatment Center. The work hardening began on 01/19/05 and was completed on 03/08/05. The initial behavioral medicine consultation was obtained on 12/28/04. Impairment rating evaluations were performed on multiple dates throughout the course of treatment. On 02/12/04, a designated doctor evaluation was performed by Peter Foon, M.D. who assigned a 5% whole person impairment rating for a baseline lumbar spine DRE Category II. He assigned a 0% whole person impairment rating for the knee. An RME was performed on 01/14/05 at Optima Medical Group by Brett Bolte, M.D. He felt that the patient had reached maximum medical improvement status. A designated doctor examination was ordered and performed at Churchill Evaluation Center on 04/07/05 by R. Hilliard, M.D. who assigned a 1% whole person impairment rating.

DISPUTED SERVICE(S)

Under dispute is retrospective medical necessity of work hardening, FCE, and biofreeze tube for the dates 1-19-05 thru 3-8-05.

DETERMINATION/DECISION

The Reviewer agrees with the determination of the insurance carrier.

RATIONALE/BASIS FOR THE DECISION

It is the determination of this reviewer that the performance of the work hardening program is not supported by the clinical documentation for the following reasons. Firstly, a work hardening program is defined in medicine ground rules as a highly structured, goal-oriented, individualized treatment program designed to maximize the ability of the person served to return to work. Work hardening programs are interdisciplinary in nature with the capability of addressing the functional, physical, behavioral, and vocational needs of the injured worker. Work hardening provides a transition between management of the initial injury and return to work while addressing the issues of productivity, safety, physical tolerances, and work behaviors. Work hardening programs use real or simulated activities in a relevant work environment in conjunction with physical conditioning tasks. These activities are used to progressively improve the biomechanical, neuromuscular, cardiovascular/metabolic, behavioral, attitudinal, and the vocational functioning of the person served.

Firstly, the clinical records do not include any attempt to contact the employer to determine the possibility of return to work in a light/modified duty capacity. Secondly, the FCE provided fails to document a full/maximal effort. The utilized methodologies to determine full effort include elevation of heart rate within expected levels to indicate full/maximum effort. Secondly, there are no specific job duties outlined to include specific requirements of lifting or other pertinent job duties. Third, the initial behavioral medical consultation does not reveal significant psychosocial barriers to recovery that would warrant or support the need for psychological treatment as a component of a work hardening program. The first BDI-II was recorded as an 8, and the BAI was scored as a 6, both revealing minimal anxiety and depression. With no evidence of depression or anxiety, it is my opinion that the psychological component of a work hardening program is not indicated.

It is therefore the Reviewer's medical opinion that the clinical records in this case fail to support the medical necessity of a work hardening program performed on this patient from 01/19/05 through 03/08/05.

Screening Criteria

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