



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: Rehab 2112 P O BOX 671342 Dallas, Texas 75267-1342	MDR Tracking No.: M5-05-2884-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Insurance Company of the State of PA Box 19	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. Position summary: Services are medically necessary.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No documentation provided. No position statement provided.

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

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
06-28-04 to 08-19-04 (except for 8-11-04 code 97545-WH-CA)	97545-WH-CA 21 units @ \$128.00 per unit = \$2,688.00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$10,316.00
	97546-WH-CA 5 units @ \$64.00 = \$320.00 X 16 DOS = \$5,120.00		
	4 units @ \$64.00 = \$256.00 X 3 DOS = \$768.00		
	3 units @ \$64.00 = \$192.00 X 1 DOS = \$192.00		
	4 units @ \$64.00 X 1 DOS = \$64.00		
	2 units @ \$64.00 = \$128.00 X 2 DOS = \$256.00		
	97546-WH-CA-59-52 3 units @ \$16.00 = \$48.00 X 4 DOS= \$192.00 (requestor was contacted and clarification of services billed obtained)		
	97750-FC (12 units @ \$444.00 X 1 DOS = \$444.00 8 units @ \$296.00 X 2 DOS = \$592.00		

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 \$10,316.00.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by Medical Dispute Resolution.

On 08-04-05, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

CPT code 97545-WH-CA date of service 08-11-04 denied with denial code "D" (duplicate). The carrier's EOB indicates a payment of \$128.00. The requestor was contacted and verification was made that no payment had been made. The carrier was also contacted and verified no payment had been made. Since neither party submitted an original EOB the review will be per Rule 134.202. Reimbursement is recommended in the amount of **\$128.00**.

CPT code 99455-WP-V3 date of service 09-10-04 denied with denial code "V" (unnecessary medical treatment with peer review). This service per Rule 134.202(E)(6)(B)(iii) is a required medical exam and is not subject to an IRO review. Reimbursement is recommended in the amount of **\$195.00**.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, Rule 134.202 and Rule 134.202(E)(6)(B)(iii).

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 \$10,639.00. 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 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:

09-21-05

Authorized Signature

Date of Findings and Decision

Order by:

09-21-05

Authorized Signature

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.

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

Phone: 512-402-1400

FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-05-2884-01
Name of Patient:	_____
Name of URA/Payer:	Rehab 2112
Name of Provider: (ER, Hospital, or Other Facility)	Rehab 2112
Name of Physician: (Treating or Requesting)	Jeff Powell, DC

August 29, 2005

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Texas Workers Compensation Commission

CLINICAL HISTORY

Available documentation received and included for review consists of treatment records from Accident & Injury, Dr. Stolz, (DC); work hardening records from Rehab 2112, Dr. Jeff Powell (DC) including sequential FCE's; Impairment rating Dr. Bennett (DC); consult reports Drs Farhat (MD), Padilla (MD), MRI reports (lumbar and cervical spine, right ankle and brain), EMG/NCV report, X-ray reports (cervical, thoracic, lumbar, right elbow, right ankle); peer report from Dr. Blanchette (PM&R), is agreed to Dr. report, Joan Coria, (MD)

Case Summary:

Mr. ____, a 31-year-old male, injured his neck, mid and lower back, as well as his ankle and elbow after he fell off the back of a trash truck, hitting his head with a reported loss of consciousness. He was taken by ambulance to the ER, evaluated and released and then started chiropractic care with Accident Injury clinic. He was assessed with a cervical, thoracic, lumbar and ankle sprain/strain injuries along with tension type headaches. He was taken off and remained

off work. He was prescribed medication through Dr. Padilla. Multiple diagnostics were performed including MRIs of the cervical thoracic and lumbar spines which were all essentially normal. Electrodiagnostic revealed evidence of right L5 nerve irritation.

He was then referred for work hardening in August of 2004. He was placed on a work hardening program between 6/30/04-8/17/04

The patient's job had been identified to fall within the heavy physical demand level category.

The initial FCE 6/28/04 determined that he was functioning at a light physical demand level with significant psychosocial risk factors. Interim FCE 7/28/04 after 16 sessions showed an increase in his capacity to the medium level with the ability to lift 50 lbs. Final FCE on 8/19/04 showed a heavy PDC, with the patient being able to lift over 100 Lbs. An impairment rating performed on 9/10/04 assessed a 10% whole person impairment comprised of category II specific disorders of the cervical and lumbar spine.

REQUESTED SERVICE(S)

Medical necessity of work hardening program, 97545-WHCA, 97546-WHCA, 97750 physical performance test.

DECISION

Approved. There is establishment of medical necessity for all disputed services, including work hardening and capacity evaluations.

RATIONALE/BASIS FOR DECISION

The patient had undergone extensive conservative care measures. He remained off work for longer than four months. He remained with some functional and strength deficits that precluded a return to work. Volitional effort had been questioned in a functional capacity environment, along with anxiety and depressive disturbances. These issues combined to be barriers to recovery unless addressed. Considering the length of time since his injury, a more intensive multidisciplinary approach would appear to be viable in this case.

Work hardening involves a multidisciplinary approach and is reserved typically for outliers of the normal patient population, i.e. poor responders to conventional treatment intervention, with significant psychosocial issues and extensive absence from work⁽³⁾.

The standard of medical necessity in Workers Comp, according to the Texas labor code 408.021 (entitlement to medical benefits) is that an employee who sustained a compensable injury is entitled to all healthcare reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to healthcare that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment.

The patient entered the work hardening program and demonstrated improvement between the three function capacity evaluations. He completed the program at a heavy physical demand level, as required by his employer. As such, medical necessity for the services has been satisfied

References:

1/ CARF Manual for Accrediting Work Hardening Programs

2/ AMA Guides to the Evaluation of Physical Impairment, 4th Edition

The above analysis is based solely upon the medical records/tests submitted. It is assumed that the material provided is correct and complete in nature. If more information becomes available at a later date, an additional report may be requested. Such and may or may not change the opinions rendered in this evaluation.

Opinions are based upon a reasonable degree of medical/chiropractic probability and are totally independent of the requesting client.