



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

Requestors Name and Address: Rehab 2112 P. O. Box 671342 Dallas, TX 75267	MDR Tracking No.: M5-05-3015-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: American Home Assurance Company, Box 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 package. Position summary states, "Services are medically necessary."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response.

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)
7-14-04 – 8-24-04 (see note below)	CPT code 97545-WH-CA (1 unit @ \$128.00 X 25 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$3,200.00
7-14-04 – 8-24-04 (see note below)	CPT code 97546-WH-CA (\$64.00 X 110.5 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$7,072.00
Grand Total			\$10,272.00

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.

In accordance with Rule 133.308 (e) dates of service 7-8-04 – 7-13-04 were not timely filed and will not be a part of this review.

Note: Dates of service 8-17-04 through 8-24-04 were denied by the carrier as “J - reimbursement is being withheld as the claim has been denied.” However, the insurance carrier response received on 7-21-05 states that these services were denied “per peer review – not reasonable and necessary.” The IRO confirmed that these services are medically necessary. They will be reimbursed as shown above.

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 \$10,272.00.

Based on review of the disputed issues within the request, the 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 7-29-05 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 97750-FC on 8-3-04 was reimbursed by the carrier and will not be a part of this review.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and Rule 134.202(c)(1).

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 carrier must refund the amount of the IRO fee to the requestor within 30 days of receipt of this order. The Division has determined that the requestor is entitled to reimbursement in the amount of \$10,272.00. 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:

_____	Donna Auby	2-6-06
Order by:	_____	_____
_____	Amy Rich	2-6-06
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.

IRO America Inc.

An Independent Review Organization

7626 Parkview Circle

Austin, TX 78731

Phone: 512-346-5040

Fax: 512-692-2924

September 16, 2005

TWCC Medical Dispute Resolution

Fax: (512) 804-4868

Patient: _____
TWCC #: _____
MDR Tracking #: M5-05-3015-01
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: notes from Michelle Ivey DC and Kenneth Wise Psy. D., notes from Francisco Batlle MD, notes from Nick Padron MD, NCV/EMG from Metroplex Diagnostics, Cervical MRI, Cervical/Thoracic/Lumbar X-Ray report from Lone Star Radiology, Lumbar MRI, Brain MRI, Narrative report from treating doctor, Operative report from RHD Medical Center, Peer review from Timothy Fahay DC, DDE fro Scott Nelson MD, notes from Marlon Padilla MD, FCE notes.

CLINICAL HISTORY

This patient stated she was injured on ___ in a work related injury. She stated she slipped on a wet floor, fell backward and landed on concrete with acute onset of neck pain that she

described as a “constant deep ache” with intermittent “electric shock pain” into the left upper extremity.

DISPUTED SERVICE(S)

Under dispute is retrospective medical necessity of work hardening 97545-WH-CA and work hardening each additional hour 97456-WH-CA for dates of service 7/14/2004 through 8/24/2004.

DETERMINATION/DECISION

The Reviewer disagrees with the determination of the insurance carrier.

RATIONALE/BASIS FOR THE DECISION

The time in which the patient was introduced to a work hardening program fits within the *Texas Workers’ Compensation Commission Spinal Treatment Guideline §134.1001* and the *Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters*. From the date of injury, the passive care and work hardening were performed within the primary levels of care and appear to be reasonable and necessary based on the medical information provided.

Screening Criteria

1. Specific:

Texas Workers’ Compensation Commission Spinal Treatment Guideline §134.1001

Texas Guidelines 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 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

YOUR RIGHT TO REQUEST A HEARING

Either party to medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk
P.O. Box 17787
Austin, Texas 78744
Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 16th day of September, 2005.

Name and Signature of Ziroc Representative: