



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: Rehab 2112 PO Box 671342 Dallas TX 75267-1342	MDR Tracking No.: M5-05-3025-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Federal Insurance Company 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

TWCC 60 package, Explanations of Benefits, and CMS 1500s.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

TWCC 60 response and RME report.

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)
7-26-04 to 8-3-04	97545-WH-CA \$128.00 x 7 = \$896.00 97546-WH-CA \$320.00 x 5 = \$1600.00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2,496.00

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 prevailed on the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$2,496.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 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 \$2,496.00. In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee of \$460.00. The Division hereby **ORDERS** the insurance carrier to remit both 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 and Order by:

Authorized Signature

Typed Name

9-16-05

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.



**PROFESSIONAL
ASSOCIATES**

NOTICE OF INDEPENDENT REVIEW

NAME OF PATIENT:	
IRO CASE NUMBER:	M5-05-3025-01
NAME OF REQUESTOR:	Rehab 2112
NAME OF PROVIDER:	Shane Marcum, D.C.
REVIEWED BY:	Board Certified in Chiropractics
IRO CERTIFICATION NO:	IRO 5288
DATE OF REPORT:	09/07/05

Dear Rehab 2112:

Professional Associates has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO) (#IRO5288). Texas Insurance Code Article 21.58C, effective September 1, 1997, allows a patient, in the event of a life-threatening condition or after having completed the utilization review agent's internal process, to appeal an adverse determination by requesting an independent review by an IRO.

In accordance with the requirement for Texas Workers' Compensation Commission (TWCC) to randomly assign cases to IROs, TWCC has assigned your case to Professional Associates for an independent review. The reviewing physician selected has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, the reviewing physician reviewed relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal. determination, and any documentation and written information submitted in support of the appeal.

This case was reviewed by a physician reviewer who is Board Certified in the area of Chiropractics and is currently listed on the TWCC Approved Doctor List.

I am the Secretary and General Counsel of Professional Associates and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for determination prior to referral to the Independent Review Organization.

REVIEWER REPORT

Information Provided for Review:

An Employer's First Report of Injury or Illness dated ____

An emergency room record from St. Paul University dated 04/05/04 and signed by an unknown physician (the signature was illegible)

CT scans of the head and brain dated 04/05/04 and interpreted by Lamita Dawson-Jones, M.D.

X-rays of the cervical spine, lumbar spine, and chest dated 04/05/04 and interpreted by Lee Wadford, M.D.

Additional x-rays of the cervical spine, lumbar spine, and thoracic spine dated 04/06/04 and interpreted by Tamara Uptigrove, D.C.

An MRI of the brain dated 04/07/04 and interpreted by Eric Bennos, M.D.

An initial report dated 04/07/04 from Shane Marcum, D.C.

A treatment plan dated 04/07/04 from Dr. Marcum

A diagnostic and treatment sheet dated 04/07/04, presumably from Dr. Marcum (no signature was available)

An intake medical report dated 04/08/04 from D.G. Edwards, D.O.

An internal radiographic report dated 04/08/04 from an unknown physician (the signature was illegible)

Therapy notes from Accident and Injury Chiropractic (presumably Dr. Marcum) dated 04/08/04, 04/09/04, 04/10/04, 04/12/04, 04/13/04, 04/16/04, 04/17/04, 04/19/04, 04/21/04, 04/22/04, 04/23/04, 04/26/04, 04/27/04, 04/28/04, 04/29/04, 04/30/04, 05/03/04, 05/04/04, 05/05/04, 05/07/04, 05/10/04, 05/11/04, 05/12/04, 05/13/04, 05/14/04, 05/17/04, 05/18/04, 05/20/04, 05/21/04, 05/24/04, and 05/28/04

MRI scans of the left shoulder, cervical spine, and lumbar spine dated 04/12/04 and interpreted by Kenneth Lustik, D.A.C.B.R.

Electrodiagnostic studies of the bilateral upper and lower extremities dated 04/19/04 from an unknown provider (no name or signature was legible) at Metroplex Diagnostics

A musculoskeletal examination dated 04/20/04 from the unknown provider at Accident and Injury Chiropractic.

An NCV study of the upper and lower bilateral extremities dated 04/26/04 and interpreted by Natalia Kogan, D.C.

Musculoskeletal examination dated 05/06/04 and 05/26/04 from Accident and Injury Chiropractic with an unknown provider (no name or signature was available)

An evaluation with Dr. Edwards dated 05/10/04

An evaluation on 05/20/04 from James Laughlin, D.O.

An initial comprehensive patient examination at Rehab 2112 from an unknown chiropractor (the signature was illegible)

Daily therapy notes at Rehab 2112 on 06/08/04, 06/10/04, 06/11/04, and 06/22/04

An initial Functional Capacity Evaluation (FCE) dated 06/24/04 from Farid Aminzadeh, D.C. and Paula Horn, M.P.T.

Work hardening notes with Dr. Aminzadeh dated 06/28/04, 06/29/04, 06/30/04, 07/01/04, 07/02/04, 07/05/04, 07/06/04, 07/08/04, 07/09/04, 07/12/04, and 07/13/04

Work hardening pain management summary dated 06/29/04 and 07/06/04 from the work hardening team (the signatures were illegible)

Additional work hardening notes from Rehab 2112 dated 07/13/04, 07/14/04, 07/15/04, 07/16/04, 07/19/04, 07/20/04, 07/21/04, 07/22/04, 07/23/04, 07/26/04, 07/27/04, 07/28/04, 07/29/04, 07/30/04, 08/02/04, 08/03/04, 08/04/04, 08/05/04, and 08/06/04

A consultation report dated 07/13/04 from David Graybill, D.O.

A procedure note dated 07/15/04 from Dr. Graybill

Case management summary dated 07/20/04 regarding the patient's work hardening program from the work hardening team (again, those signatures were illegible)

An interim FCE dated 07/22/04 and signed by Tony Bennett, D.C. and Ms. Horn.

Additional case management summary from the patient's work hardening program dated 07/27/04 and 08/05/04

A letter of medical necessity dated 10/20/04 and signed by an unknown provider (no name or signature was available on the note)

Another letter of medical necessity dated 10/26/04 from Michelle Ivey, D.C.

Clinical History Summarized:

The Employer's First Report of Injury or Illness stated the patient was injured on ___ when he was involved in an auto accident that resulted in neck and back pain. X-rays of the cervical spine dated 04/05/04 revealed moderately severe degenerative disc disease at C6-C7 and slight wedging of the superior surface of C4, which was felt to be old. Lumbar spine x-rays revealed severe degenerative disc disease at L5-S1. The patient was initially evaluated on 04/07/04 by Dr. Marcum and therapy was recommended for an unknown duration. The patient attended therapy at Accident and Injury Chiropractic from 04/08/04 through 05/28/04. MRI scans of the left shoulder, lumbar spine, and cervical spine were obtained on 04/12/04. An electrodiagnostic study dated 04/26/04 revealed evidence of axonal peripheral neuropathy. On 06/24/04, the patient was functioning in the light to medium physical demand level per an initial FCE. The patient attended a work hardening program from 06/28/04 through 08/06/04 with Dr. Aminzadeh and other multiple providers. The patient received a lumbar epidural steroid injection (ESI) on 07/16/04 from Dr. Graybill. An interim FCE dated 07/22/04 revealed the patient was currently functioning in the medium physical demand level. A letter of medical necessity dated 10/20/04 noted an FCE to assess the necessity for work hardening was obtained on 06/24/04. The initial and interim FCE were reviewed. Another letter of medical necessity dated 10/26/04 from Dr. Ivey requested reconsideration of the issue and compensation.

Disputed Services:

The work hardening program from 07/26/04 through 08/03/04

Decision:

I agree with the requestor. The work hardening program from 07/26/04 through 08/03/04 was reasonable and medically necessary.

Rationale/Basis for Decision:

The question was whether the treatment provided to the patient satisfies the qualifications in Section 408.021 of the Texas Labor Code, which only substantiated the need for care, which (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 retain employment. Based upon review of the medical documentation, the patient's condition appeared to progress at a reasonable pace under the treatment provided in the work hardening program. Therefore, based upon the supplied documentation, the above mentioned services provided between 07/26/04 and

08/03/04, including the work hardening program, do satisfy the qualifications of Section 408.021 and were, therefore, reasonable and necessary as related to the original injury.

This review was conducted on the basis of medical and administrative records provided with the assumption that the material is true and correct.

This decision by the reviewing physician consulting for Professional Associates is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

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

A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk **within twenty (20) calendar days** of your receipt of this decision (28 Texas Administrative Code 148.3).

This decision is deemed received by you **five (5) calendar days** after it was mailed and the first working day after the date this decision was placed in the carrier representative's box (28 Texas Administrative Code 102.5 (d)). A request for a hearing should be faxed to 512-804-4011 or sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P. O. Box 17787
Austin, TX 78744

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization's decision was sent to TWCC via facsimile or U.S. Postal Service on 09/07/05 from the office of Professional Associates.

Sincerely,

Lisa Christian
Secretary/General Counsel