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 P O BOX 671342 Dallas, Texas 75267-1342	MDR Tracking No.: M5-05-3079-01 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

Documentation submitted: TWCC-60, explanation of benefits, CMS 1500s. Position summary: Services are medically necessary.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documentation submitted: Response to TWCC-60, explanation of benefits, CMS 1500s. Position summary: No further payment was recommended towards the amount in dispute.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
08-05-04 to 08-24-04	97545-WH-CA and 97546-WH-CA	☐ Yes ☒ No	$0.00

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 not prevail on the disputed medical necessity issues.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308

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 not entitled to reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

		09-19-05
Authorized Signature		Date of Findings and Decision

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.

7600 Chevy Chase, Suite 400
Austin, Texas 78752
Phone: (512) 371-8100
Fax: (800) 580-3123

NOTICE OF INDEPENDENT REVIEW DECISION

Date: September 16, 2005

To The Attention Of:

DWC
7551 Metro Center Drive, Suite 100, MS-48
Austin, TX 78744-16091

RE: Injured Worker:
MDR Tracking #: M5-05-3079-01
IRO Certificate #: IRO 5263

Forté has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Division of Workers' Compensation (DWC) at the Texas Department of Insurance has assigned the above referenced case to Forté for independent review in accordance with DWC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, 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 was reviewed.

The independent review was performed by a Chiropractic reviewer who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- Statement letter
- Table of disputed services
- FCE reports
- EOBs
- HCFA 1500's
- Work hardening notes
- Exercise logs
- Psychologist notes
- Medical history
- Treating doctor examination reports
- X-ray reports
- MRI reports
- EMG/NCV reports
- Referral doctor notes

- Referral forms
- TWCC reports

Submitted by Respondent:

- Hospital notes
- Peer reviews
- Daily notes
- Referral doctor notes
- TWCC forms
- FCE reports
- Work hardening notes
- Super bills
- Documentation from a prior injury

Clinical History

According to the supplied documentation, the claimant sustained an injury in the normal course and scope of his employment when lifting caused back pain on ___. The claimant initially did not seek care, but was later seen at the emergency room. The claimant was diagnosed with a lumbar sprain and given medications. The claimant later sought treatment with Ramesh Saghani, D.C. at the Accident and Injury Clinic. Chiropractic therapies began. On 5/14/04, an MRI of the lumbar spine revealed a broad based posterior bulge at L4/5 and a central contained disc protrusion at L5/S1. The MRI report also revealed disc desiccation within the L5 disc. Both bulges did not contact the thecal sac. On 6/24/04, the claimant underwent an NCV of the lower extremities. The NCV was negative. The claimant began a work hardening program. The claimant underwent approximately 30 work hardening sessions. The documentation continues beyond this date but was not reviewed.

Requested Service(s)

Work hardening program (97545-WH-CA and 97546-WH-CA) for dates of service 8/5/04 through 8/24/04

Decision

I agree with the carrier that the services in dispute were not medically necessary.

Rationale/Basis for Decision

According to the supplied documentation, this claimant sustained an injury to his lumbar spine on ___. The claimant underwent a normal regimen of chiropractic passive and active modalities. The NCV performed revealed no abnormalities. An FCE was performed on 7/7/04 that revealed the claimant was at a medium physical demand level which was less than his work level of medium/heavy. A second FCE was performed on 8/3/04 which placed the claimant at a medium/heavy physical demand level and the claimant's job at a medium/heavy physical demand level. At that time, the claimant was able to perform his normal job activities. Continuing in an ongoing work hardening program is not seen as medically necessary. A note from the carrier dated 5/20/04, shortly after treatment began with the chiropractor, the employer reported that sedentary duty up to normal duty was available to help the claimant return to work. After extensive chiropractic care, a brief work hardening program and a return to a medium/ heavy physical demand level, a return to work protocol was indicated. With the availability of work and level of the claimant's abilities, the disputed services were not objectively supported.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to DWC via facsimile or U.S. Postal Service from the office of the IRO on this 16th day of September 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder