



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:	MDR Tracking No.: M5-05-3126-01
Edward F Wolski MD/Wol + Med 2436 I-35 East, South, Suite 336 Denton TX 76205	Claim No.:
	Injured Worker's Name:
Respondent's Name and Address:	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:
American Home Assurance Box 19	

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DWC-60 package. Position Summary: We have graphs for this patient showing improvement from the physical therapy that she received in our office during the time range that is being denied.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Response to DWC-60 package. Position Summary: Per peer review, not medically reasonable or necessary and one on one not supported.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
8-5-04 to 9-10-04	97110 (\$34.46 x 13 days = \$447.98) 97113 (\$38.91 x 11 days = \$428.01) 97530 (\$34.65 x 13 days = \$450.45)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,326.44
	A9150 (reimbursement assigned by carrier per Rule 134.202(c) (6))	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Assigned by carrier
	TOTAL		\$1,326.44 plus amount for A9150

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.

Code A9150 – Per Rule 134.202 (c) (6) for products and services for which CMS or the Division does not establish a relative value unit and/or a payment amount, the carrier shall assign a relative value which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments.

Per carrier response and EOB, code 97113 for date of service 9-8-04 was paid on 7-5-05 and will not be part of this review.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.202

PART VII: DIVISION DECISION AND ORDER

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 additional reimbursement in the amount of \$1,326.44 plus the amount for A9150. 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 \$650.00. 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.

Ordered by:

_____, Medical Dispute Officer

12-16-05

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

December 6, 2005

TDI-DWC Medical Dispute Resolution
Fax: (512) 804-4868

Patient: _____
TDI-DWC #: _____
MDR Tracking #: M5-05-3126-01
IRO #: 5251

IRO America Inc. (IRO America) has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI, Division of Workers' Compensation (DWC) has assigned this case to IRO America for independent review in accordance with DWC 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 MD, board certified and specialized in Physical Medicine. The reviewer is on the DWC 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 the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carriers health care providers who reviewed the case for decision before 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, records from the Requestor, Respondent, and Treating Doctor(s), including: Treating doctor's progress notes, pain evaluations, and psychological evaluations.

CLINICAL HISTORY

This patient sustained a right shoulder injury on ____, and after failing conservative therapy, underwent shoulder surgery including distal clavicular resection in February, 2004. She subsequently underwent physical rehabilitation.

DISPUTED SERVICE(S)

Under dispute is the retrospective medical necessity of therapeutic exercises, aquatic therapy, therapeutic activities, non-prescription drugs for the dates 8/5/04 thru 9/10/04.

DETERMINATION/DECISION

The Reviewer disagrees with the determination of the insurance company.

RATIONALE/BASIS FOR THE DECISION

The Patient was reportedly seen by her orthopedic surgeon on 7-19-04, at which time he is said to have ordered another 6 weeks of physical therapy. This follows notes of the provider during the disputed dates that the therapy was helping the patient to improve in strength and lessen her pain. Since rotator cuff surgeries can take up to a year for full rehab to occur, this sequence of events does not seem to be unreasonable

Screening Criteria

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 DWC or other State of Texas Agencies; standards contained in Medicare Coverage Database; ACOEM Guidelines; peer-reviewed literate 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 facsimile, a copy of this finding to the DWC.

Sincerely,

IRO America Inc.



Dr. Roger Glenn Brown

President & Chief Resolutions Officer

Your Right To Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). 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. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

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 DWC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to DWC via facsimile, on this 6th day of December, 2005.

Name and Signature of IRO America Representative:

Sincerely,

IRO America Inc.

A handwritten signature in black ink, appearing to read "Roger Glenn Brown", with a long horizontal flourish extending to the right.

Dr. Roger Glenn Brown

President & Chief Resolutions Officer