



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 Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address: Easter Seals East Texas DBA Brazos Valley Rehabilitation Center 1318 Memorial Drive Bryan, Texas 77802	MDR Tracking No.: M5-05-3195-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Insurance Company Box 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: TWCC-60 package, explanations of benefits, CMS 1500s
 POSITION SUMMARY: "Increased supervised Physical Therapy due to high risk of re-injury" per table of disputed services

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to TWCC-60 and explanations of benefits
 POSITION SUMMARY: This dispute involves the carrier's payment for date of service 08/18/2004 to 11/5/2004. The requester billed \$5,200; Texas Mutual paid \$2,233.98. The requester believes it is entitled to an additional of \$2,245.82

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
08-18-04 to 11-05-04	97110	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2,245.82

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 additional amount due from the carrier for the medical necessity issues equals **\$2,245.82**.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308

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 \$2,245.82. 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:

10-13-05

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.



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

NOTICE OF INDEPENDENT REVIEW DECISION

Date: October 12, 2005

To The Attention Of: DWC
7551 Metro Center Drive, Suite 100, MS-48
Austin, TX 78744-16091

RE: Injured Worker:
MDR Tracking #: M5-05-3195-01
IRO Certificate #: IRO 5263

Forté has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The TDI/Division of Workers' Compensation (DWC) has assigned the above referenced case to Forté for independent review in accordance with Texas Insurance Code 21.58C and the rules of TDI/DWC 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 an Orthopedic reviewer (who is board certified in orthopedic surgery) 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:

- Prescription for right knee therapy status post anterior cruciate ligament revision and reconstruction with osteochondral allograft and partial medial meniscectomy
- Physical Therapy evaluations beginning on 8/16/04 thru 11/5/04
- Physical therapy discharge summary on 11/8/04

Submitted by Treating Doctor:

- Clinic notes from Dr. Buford including initial evaluation showing the patient had first injury on ____
- Operative note from Dr. Buford dated 6/21/04 for right knee anterior cruciate ligament reconstruction using Achilles tendon allograft and right knee osteochondral allograft to medial femoral condyle and right knee partial medial meniscectomy
- Post-operative notes from Dr. Buford for follow-up through 5/10/05

Submitted by Respondent:

- None submitted

Clinical History

The patient incurred a previous right knee injury and underwent previous right knee anterior cruciate ligament reconstruction with bone tendon allograft and partial medial meniscectomy in January of 2000. The patient is status post anterior cruciate ligament reconstruction with tendon bone allograft reconstruction and medial collateral ligament repair in August of 2000 from a volleyball injury. These surgeries were performed by Dr. Shinberg. On ____, the patient incurred injury to her right knee when she was running on a soccer field. The patient had symptoms and clinical examination consistent with anterior cruciate ligament tear. Dr. Buford performed right knee reconstruction with the anterior cruciate ligament using Achilles tendon allograft with right knee osteochondral allograft medial femoral condyle and right knee partial medial meniscectomy. Post-operatively the patient had a full course of therapy from 8/18/04 thru 11/5/04.

Requested Service(s)

Therapeutic exercises (97110) for dates of service 8/18/04 to 11/5/04

Decision

I disagree with the insurance company and feel that the services performed are reasonable and medically necessary.

Rationale/Basis for Decision

Given the severity and complexity of the type of surgery performed for her right knee, the postoperative therapy between 8/18/04 and 11/05/04 is indicated. The patient had her third surgery to her knee and needed the therapy to regain her range of motion and strength of her right knee. I agree that there was medical necessity for the therapy as requested and performed.

In accordance with Divison 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 12th day of October 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder