**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.: M5-05-3265-01 |
|---|---|
| **NORTH TEXAS PAIN RECOVERY CENTER**<br>**6702 WEST POLY WEBB ROAD**<br>**ARLINGTON TX 76016** | Claim No.: |
| | Injured Worker's Name: |
| Respondent's Name and Address: | Date of Injury: |
| **NEW HAMPSHIRE INSURANCE CO**<br>**C/O FOL BOX 19** | Employer's Name: |
| | Insurance Carrier's No.: |

**PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY**

DWC-60 package. Position summary: Medically necessary per treating physician.

**PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY**

DWC-60 response. Position summary: None submitted.

**PART IV: SUMMARY OF DISPUTE AND FINDINGS**

| Date(s) of Service | CPT Code(s) or Description | Medically Necessary? | Additional Amount Due (if any) |
|---|---|---|---|
| 3-21-05 TO 3-25-05 | 97545-WH-CA & 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.

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 9-7-05, Medical Review 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.

Codes 97545-WH-CA & 97546-WH-CA billed on 4-11-05 to 4-22-05 were partially paid with denial reason W1, disciplinary programs not accredited by CARF are reduced below the MAR for that program. Requestor submitted proof of CARF accreditation. Therefore, recommend additional reimbursement as follows:

$25.60 x 2 days = $51.20
$77.20 x 1 day = $77.20
$13.40 x 1 day = $13.40
$76.80 x 1 day = $76.80
TOTAL $218.60

On 10-4-05, the requestor submitted a letter of withdrawal for codes 97545-WH-CA & 97546-WH-CA billed on 4-25-05 to 4-29-05. Therefore, these dates of service are not in review.

## PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 133.307, 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 additional reimbursement for the services involved in this dispute in the amount of $218.60 but is not entitled to a refund of the paid IRO fee.

**Findings and Decision by:**

| | Medical Dispute Officer | 12-22-05 |
|---|---|---|
| Authorized Signature | Typed Name | Date |

## 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:** M5-05-3265-01
**NAME OF REQUESTOR:** North Texas Pain Recovery Center
**NAME OF PROVIDER:** David Livingston, M.D.
**REVIEWED BY:** Board Certified in Orthopedic Surgery
**IRO CERTIFICATION NO:** IRO 5288
**DATE OF REPORT:** 09/27/05 (REVISED 12/15/05)

Dear North Texas Pain Recovery Center:

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 TDI-Division of Workers' Compensation (DWC) to randomly assign cases to IROs, DWC 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 Orthopedic Surgery and is currently listed on the DWC 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 the provider, the injured employee, or employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the Independent Review Organization.

## REVIEWER REPORT

**Information Provided for Review:**

Process group notes with Roger McMahon, L.M.S.W. and Jessica Link dated 03/21/05, 03/22/05, 03/24/05, 03/25/05, 04/12/05, 04/13/05, 04/14/05, 04/15/05, 04/18/05, 04/21/05, 04/22/05, 04/25/05, 04/28/05, and 04/29/05
Biofeedback group notes with Thomas F. Van Buskirk, L.P.C. dated 03/21/05, 03/23/05, 03/25/05, 04/18/05, and 04/20/05
Daily physical therapy notes with Rosann Clay, P.T. dated 03/21/05, 03/22/05, 03/23/05, 03/24/05, 03/25/05, 04/11/05, 04/12/05, 04/13/05, 04/14/05, 04/15/05, 04/18/05, 04/19/05, 04/20/05, 04/21/05, 04/22/05, 04/25/05, 04/26/05, 04/27/05, 04/28/05, and 04/29/05
Case management notes with Betty L. Lopez, L.P.C.-I. dated 03/21/05, 03/22/05, 03/23/05, 03/24/05, 03/25/05, 04/11/05, 04/12/05, 04/13/05, 04/14/05, 04/15/05, 04/18/05, 04/19/05, 04/20/05, 04/21/05, 04/22/05, 04/25/05, 04/26/05, 04/27/05, 04/28/05, and 04/29/05
Group physical rehabilitation notes with Jennifer Hernandez, M.P.T. dated 03/22/05, 04/19/05, and 04/26/05

Hypnosis group notes with Mr. Van Buskirk on 03/22/05, 03/24/05, 04/14/05, 04/19/05, 04/21/05, 04/26/05, and 04/28/05
Weekly progress reports from Ms. Lopez, Mr. Van Buskirk, Ms. Hernandez, Mr. McMahon, and Ms. Link dated 03/28/05, 04/11/05, 04/18/05, and 04/25/05
A letter of medical dispute resolution for denial of payment for work hardening from Michael R. Walker, Ed.D., M.B.A. dated 09/09/05

**Clinical History Summarized:**

The patient participated in a work hardening program from 03/21/05 through 04/29/05, which included process group with Roger McMahon, L.M.S.W., biofeedback and hypnosis with Thomas Van Buskirk, L.P.C., physical therapy with Rosann Clay, P.T., case management with Betty L. Lopez, L.P.C.-I., and group physical rehabilitation with Jennifer Hernandez, M.P.T. On 09/09/05, Michael R. Walker, Ed.D., M.B.A. wrote a letter to the Medical Dispute Resolution department of the Texas Workers' Compensation Commission (TWCC) regarding denial of payment for the work hardening program from 03/21/05 through 04/29/05. He felt the patient
was an appropriate referral for work hardening and noted that both the treating doctor and Designated Doctor recommended work hardening

**Disputed Services:**

A work hardening program from 03/21/05 through 04/29/05

**Decision:**

I disagree with the requestor. The work hardening program was neither reasonable nor necessary.

**Rationale/Basis for Decision:**

The screening criteria included the use of the *AECOM Guidelines* and *Phase III Clinical Guidelines* for the treatment of chronic lower back pain. Work hardening is a specific program that includes both physical, as well as emotional support. The patient received a great deal of treatment in this work hardening that was unnecessary. There was no necessity for the psychological portions. In my opinion, work hardening was neither reasonable nor necessary.

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 Division decision and order.

## YOUR RIGHT TO REQUEST A HEARING

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. A request for a hearing should be faxed to 512-804-4011 or sent to:

Chief Clerk of Proceedings/Appeals Clerk
TDI-Division of Workers' Compensation
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 DWC via facsimile or U.S. Postal Service on 09/27/05 from the office of Professional Associates.

Sincerely,

_____
Lisa Christian
Secretary/General Counsel