



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 and Fee Dispute

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, TX 75267	MDR Tracking No.: M5-05-3301-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Liberty Mutual Fire Insurance, Box 28	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC-60 form, Explanations of Benefits, medical documentation and CMS 1500's. No position summary was received.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include DWC-60 form and Explanations of Benefits. No position summary was received.

PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
8-23-04 – 10-7-04	CPT codes 97545-WH-CA, 97546-WH-CA, 97546-WH-CA-59	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0

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

Findings and Decision by:

11-22-05

Authorized Signature

Typed Name

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.

NOTICE OF INDEPENDENT REVIEW DECISION

October 25, 2005

Amended Letter: November 9, 2005

Program Administrator
Medical Review Division
Division of Workers Compensation
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Claim #:
Injured Worker:
MDR Tracking #: M5-05-3301-01
IRO Certificate #: IRO4326

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

TMF has performed an independent review of the rendered 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 matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and the provider, 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 carrier health care providers who reviewed the case for decision before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient was injured on the job on ___ when he was lifting and moving several hundred boxes; he began to experience low back pain. He was initially seen by a doctor who took x-rays and prescribed medication which was not filled. A few days later he sought care from another provider. An initial evaluation was performed and revealed significant objective findings that warranted an aggressive treatment program. The program was begun and during the treatment program he received an MRI of the lumbar spine and

electro-diagnostic testing of the lower extremities. There were positive findings on both diagnostic tests that confirmed his injury and need for treatment. He was referred for a FCE on 08/17/2004. A work hardening program was started on 08/23/2004 and completed on 10/07/2004. A final FCE was done on 10/08/2004. The medical record documentation reveals that the patient was referred for the program based upon the treating doctor's questionnaires and not a psychological evaluation. On 08/24/2004 a psychological screening was performed and it reveals the patient could benefit from individual evaluation and group or WH.

Requested Service(s)

Work hardening and work hardening each additional hour

Decision

It is determined that the work hardening and work hardening each additional hour was not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

National treatment guidelines allow for work hardening programs based upon specific criteria. The initial FCE revealed the patient to be functioning at a medium job classification and that is his work requirement. It was noted that the patient lacked endurance, decreased range of motion, and was unable to complete repetitive task test even though he had already had almost two months of treatment. Also noted were several psychosocial factors. Final FCE on 10/08/2004 revealed the same job classification and minimal improvement in several areas.

The medical record documentation does not indicate that the patient required an intensive multi-disciplinary work hardening program. According to the records, he could have responded as well to a lower level of care to include work conditioning four hours per day and return to work four hours per day in conjunction with individual counseling sessions. Therefore, it was not medically necessary for this patient to receive a work hardening program from 0823/2004 through 10/07/2004.

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:dm

Attachment

Information Submitted to TMF for TWCC Review

Patient Name:

TWCC ID #: M5-05-3301-01

Information Submitted by Requestor:

None

Information Submitted by Respondent:

- MDR Request
- Notes from Chiropractic Neurologist
- Electrodiagnostic results
- MRI results
- Radiologic results
- Table of disputes
- Claims
- Work hardening review
- Rehab progress notes
- Psychology group notes
- Report of medical evaluation
- Impairment rating
- FCE