



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  
PO Box 671342  
Dallas TX 75267-1342**

MDR Tracking No.: M5-06-0215-01

Claim No.:

Injured Worker's Name:

Respondent's Name and Address:

**Argonaut Midwest Insurance Co Box 17**

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

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

DWC-60 package, EOBs, CMS-1500s. Position Summary: Services were medically necessary.

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

DWC-60 response. Position Summary: There simply is no medical documentation to substantiate the medical necessity for the treatments provided by Requestor.

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

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
9-23-04 to 9-29-04	97545-WH-CA (\$128.00 x 5 days)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$640.00
	97546-WH-CA (\$192.00 x 3 days)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$576.00
	97546-WH-CA (\$128.00 x 1 day)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$128.00
	97546-WH-CA (\$320.00 x 1 day)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$320.00
	97546-WH-CA (\$16.00 x 3 quarter hrs)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$ 48.00
		97750-FC	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	<b>TOTAL</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>\$2,008.00</b>

#### 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.

**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 \$2,008.00.

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 \$460.00. 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

11-18-05

\_\_\_\_\_  
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.**

# P-IRO

An Independent Review Organization  
7626 Parkview Circle  
Austin, Texas 78731

**Phone: 512-346-5040**

**Fax: 512-692-2924**

November 8, 2005

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

Delivered via Fax

Patient / Injured Employee \_\_\_\_\_  
TDI-DWC # \_\_\_\_\_  
MDR Tracking #: M5-06-0215-01  
IRO #: 5312

P-IRO, Inc. has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI-Division of Worker's Compensation (DWC) has assigned this case to P-IRO for independent review in accordance with DWC Rule 133.308 which allows for medical dispute resolution by an IRO.

P-IRO 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. This case was reviewed by a licensed Provider board certified and specialized in Chiropractic Care. The reviewer is on the DWC Approved Doctor List (ADL). The P-IRO 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, information provided by The Requestor, Respondent, and Treating Doctor(s), including: Lumbar MRI, designated doctor evaluation from Suzanne Page MD, medical notes from Marlon Padilla MD, notes from Concentra Medical Centers, Medical Review from Charles Crane MD, Lumbar X-Ray

## CLINICAL HISTORY

This Patient was injured on \_\_\_ while he and two other co-workers were attempting to lift a jack. He noted discomfort in his low back and within a couple of days he had pain radiating down his legs. No other information was given as to The Patient's job duties.

## DISPUTED SERVICE (S)

Under dispute is the retrospective medical necessity of work hardening (97545-WH-CA, 97546-WH-CA), and FCE (97550-FC) from 9/23/04 to 9/29/04.

## DETERMINATION / DECISION

The Reviewer disagree with the determination of the insurance carrier.

## RATIONALE/BASIS FOR THE DECISION

From the limited history given and the mechanism of injury, coupled with the findings of the MRI, it appears that the treatment given and the services in dispute are reasonable and medically necessary. These services are also reasonable and necessary according to the *Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters*. It is important to have the patient return to their employment as close to pre-accident as possible without risk or fear of re-injury. These services were performed within an appropriate time and are necessary to minimize the risk of re-injury after the patient returns back to their pre-injury employment.

### Screening Criteria

1. Specific:

Texas Workers' Compensation Commission Spinal Treatment Guideline §134.1001.

Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters.

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 literature 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

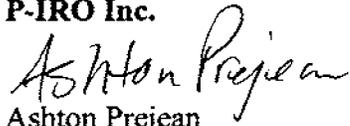
P-IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. P-IRO has made no determinations regarding benefits available under the injured employee's policy.

As an officer of P-IRO Inc., I certify that there is no known conflict between the Reviewer, P-IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

P-IRO is forwarding by mail or facsimile, a copy of this finding to the DWC, the Injured Employee, the Respondent, the Requestor, and the Treating Doctor.

Sincerely,

**P-IRO Inc.**



Ashton Prejean

**President & Chief Resolutions Officer**