



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:  <b>Rehab 2112 PO Box 671342 Dallas TX 75267-1342</b>	MDR Tracking No.: M5-06-0567-01
	Claim No.:
Respondent's Name and Address:  <b>Netherlands Insurance Co/America First Box 42</b>	Injured Worker's Name:
	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

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

DWC-60 package. Position Summary: Services are medically necessary.

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

Response to DWC-60 package. 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)
12-17-04 to 1-14-05	97545-WH-CA \$128.00 (2 hrs) x 15 days = \$1,920.00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$6,608.00
	97546-WH-CA \$320.00 (5 hrs) x 13 days = \$4,160.00		
	97546-WH-CA \$256.00 (4 hrs) x 1 day = \$256.00		
	97546-WH-CA \$192.00 (3 hrs) x 1 day = \$192.00		
	97546-WH-CA-59-52 \$16.00 (15 min) x 3 days = \$48.00		
	97546-WH-CA-59-52 \$32.00 (30 min) x 1 day = \$32.00		
12-30-04	97750-FC	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
	<b>TOTAL</b>		\$6,608.00

**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 **prevailed** on the majority of 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 \$6,608.00. 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.

**Findings & Decision by:**

Medical Dispute Officer

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Typed Name

\_\_\_\_\_  
Date

**Ordered by:**

Medical Necessity Team

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

# P-IRO

An Independent Review Organization  
7626 Parkview Circle  
Austin, Texas 78731  
**Phone: 512-346-5040**  
**Fax: 512-692-2924**

Amended January 20, 2006  
January 18, 2006

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

Delivered via Fax

Patient / Injured Employee	_____
TDI-DWC #	_____
MDR Tracking #:	M5-06-0567-01
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: explanation of reviews, notes from Kenneth Wise Psy. D., initial FCE dated 11/11/2004, interim FCE dated 12/7/2004, status FCE dated 12/30/2004, discharge FCE dated 1/14/2005, notes from treating doctor-Larry Parent DC, notes from Robert Henderson MD, notes from Fred Seals DC, notes from Tom Mayer MD, lower extremity NCV/EMG, Peer Review from Mike O'Kelley DC.

## CLINICAL HISTORY

This is a male patient who was injured on the job on \_\_\_\_\_. The Patient stated he injured his low back while bending over and pulling on a rope. The Patient went to Primacare the next day and then started treatment with the treating doctor on August 22, 2004.

## DISPUTED SERVICE (S)

Under dispute is the retrospective medical necessity of work hardening program and FCE for 12/17/2004 through 1/14/2005.

## DETERMINATION / DECISION

The Reviewer partially agrees with the determination of the insurance carrier. The Reviewer agrees with the insurance carrier on the following: FCE and the Reviewer disagrees with insurance carrier on the following: work hardening program; for the dates of service 12-17-04 thru 1-14-05.

## RATIONALE/BASIS FOR THE DECISION

It appears from the injury and the records provided that the treatment given was reasonable and medically necessary except for the FCE performed. The Patient was introduced into a rehab program in a timely manner with a reasonable positive outcome. It is important to return The Patient back into his physical demand category safely and without risk of re-injury. The FCE would not be reasonable, as performing the FCE within an eight week time period is excessive and unreasonable. In The Reviewers opinion, all the other disputed treatment is reasonable and necessary as outlined by the *Texas Guideline for Chiropractic Quality Assurance and Practice Parameters*.

### Screening Criteria

#### 1. Specific:

Texas Guideline 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 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

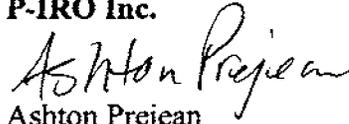
P-IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. P-IRO has made no determinations regarding benefits available under the injured employee's policy.

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.

Sincerely,

**P-IRO Inc.**



Ashton Prejean

**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.

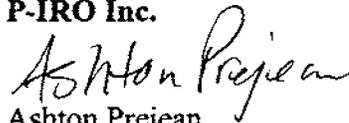
The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

**I hereby certify, in accordance with DWC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent DWC via facsimile, U.S. Postal Service or both on this 18<sup>th</sup> day of January, 2006.**

**Name and Signature of P-IRO Representative:**

Sincerely,

**P-IRO Inc.**



Ashton Prejean

**President & Chief Resolutions Officer**