



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: San Antonio Accident/Injury Care 401 W. Commerce #100 San Antonio, TX 78207	MDR Tracking No.: M5-06-0929-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: City of San Antonio, Box 42	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC-60 package. Position Summary states that the rehabilitation performed, because it was post-op, was very different in its goals from the therapy that was done before her surgery.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC-60 response. Position Summary states, "Not medically necessary."

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)
2-9-05 – 3-24-05	CPT codes 97150 and 97124	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0

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.

On 1-26-06 the requestor informed the Division that the dates of service should be 2-9-05 through 3-24-05 as supported by the CMS 1500's that were submitted with the DWC 60. Therefore, this review will encompass those dates of service.

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:

Donna Auby

3-6-06

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.



Specialty Independent Review Organization, Inc.

March 2, 2006

DWC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient: ____
DWC #: x2792353
MDR Tracking #: M5-06-0929-01
IRO #: 5284

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

Specialty IRO has performed an independent review of the care rendered 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.

This case was reviewed by a licensed Chiropractor. The reviewer is on the DWC ADL. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

According to the records received and reviewed, Ms. ____ was working for the City of San Antonio when she was injured in a work related accident on _____. Ms. ____ presented to Dr. Alexander on January 5, 2005 following surgery to Ms. ____'s right wrist. The patient had undergone carpal tunnel release with Dr. Boehme on December 7, 2004. Dr. Alexander performed post-operative rehabilitative surgery to Ms. ____ beginning about January 5, 2005 and extending through March 24, 2005 for the purpose of this review.

RECORDS REVIEWED

Medical Dispute Resolution paperwork
Numerous EOB's
Request for Reconsideration Letter from Dr. Alexander
Report from Dr. Mohamed
Letter from Harris & Harris

DISPUTED SERVICES

Services under dispute include Group Therapeutic Activities (97150) and Massage (97124) from 2-9-2005 through 3-24-2005.

DECISION

The reviewer agrees with the previous adverse determination.

BASIS FOR THE DECISION

The basis for the determination is based upon the Medical Disability Advisor, the Official Disability Guidelines, and Evidence Based Medicine Guidelines. The Medicare guidelines and payment policies were also utilized in the decision making process of this review. Specifically there is no documentation provided with this review to substantiate the need for care. Although the time frames of the care in question seem to be reasonable, there is no documentation provided for each date of service under review. In fact the only clinical documentation provided was the letter from Dr. Alexander and a report from Dr. Mohamed. Since there is no daily documentation provided, the provider fails to meet the minimum standard of documentation according to the Medicare payment policies.

REFERENCES

Medical Disability Advisor

The Official Disability Guidelines

Evidence Based Medicine Guidelines

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that the reviewing provider has no known conflicts of interest between that provider 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 carrier health care providers who reviewed the case for decision before referral to the IRO.

Sincerely,

Wendy Perelli, CEO

CC: Specialty IRO Medical Director

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.

Sincerely,

Wendy Perelli, CEO

I hereby certify, in accordance with DWC- Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the Division via facsimile, U.S. Postal Service or both on this 3rd day of March 2006

Signature of Specialty IRO Representative:

Name of Specialty IRO Representative: Wendy Perelli