



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

<b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address:	MDR Tracking No.: M5-06-0972-01
South Coast Spine and Rehab, P. A. 620 Paredes Line Road Brownsville, TX 78521	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
TX Worker's Compensation SOL, Box 19	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, "The sender of this package is requesting a Medical Dispute Resolution by an Independent Review Organization pursuant to Rule 133.308."

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

No response 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)
3-1-05	CPT code 99213	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$61.89
3-3-05	CPT code 97750-FC (\$35.63 x 12 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$427.56

#### 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 prevail on the majority of the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$489.45.

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

28 Texas Administrative Code Sec. 133.308 and 134.202(c)(1).

**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 carrier must refund the amount of the IRO fee (\$460.00) to the requestor within 30 days of receipt of this order. The Division has determined that the requestor is entitled to additional reimbursement in the amount of \$489.45. 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 and Decision and Order by:

Donna Auby

4-3-06

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.**

## NOTICE OF INDEPENDENT REVIEW DECISION

March 22, 2006

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 #: M5-06-0972-01  
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 DWC 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 sustained a work-related injury on \_\_\_ when he was carrying a door and hurt his right shoulder and lower back. He had received treatment over a period of time. He received right shoulder rotator cuff repair and open acromioplasty surgery on 10/29/2004. He responded well to a post surgical rehabilitation program. He was seen for an office visit on 03/01/2005. At that time it was determined that he needed a FCE to determine his return to work status. On 03/03/2005 a FCE was done and he was able to return to work in a heavy work category.

### Requested Service(s)

Office visit and 97750 – FC-FCE provided from 03/01/2005 through 03/03/2005

### **Decision**

It is determined that the office visit and 97750 – FC-FCE provided from 03/01/2005 through 03/03/2005 were medically necessary to treat this patient's condition.

### Rationale/Basis for Decision

National treatment guidelines allow for a FCE to ascertain an injured worker's current work status. There is sufficient documentation to clinically justify the office visit and the FCE.

Therefore, the office visit on 03/01/2005 was medically necessary to appropriately assess this patient's response to his post surgical rehabilitation. The FCE was medically necessary to evaluate his current condition and his ability to return to work in a heavy category.

This decision by the IRO is deemed to be a DWC decision and order.

### **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,

A handwritten signature in black ink, appearing to read "Gordon B. Strom, Jr.", written in a cursive style.

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

GBS:dm

Attachment

Information Submitted to TMF for Review

Patient Name:

Tracking #: M5-06-0972-01

**Information Submitted by Requestor:**

- Final request for Medical Dispute Resolution
- Chronological order of case management
- Re-Evaluation narratives
- Report of the MRI of the right shoulder
- Report of the MRI of the lumbar spine
- Functional capacity evaluations
- Orthopedic notes
- Specific and subsequent medical reports

**Information Submitted by Respondent:**