



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

<b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor=s Name and Address:	MDR Tracking No.: M5-06-1125-01
Rehab 2112 P. O. Box 671342 Dallas, TX 75267	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:
Hartford Underwriters Insurance, Box 27	

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

Documents include the DWC 60 package. Position summary states, "The services were medically necessary. The carrier did not pay bills according to our CARF accreditation."

#### 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)
5-26-05 – 6-13-05	CPT code 97545-WH-CA (\$128.00 X 10 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,280.00
5-26-05 – 6-13-05	CPT code 97546-WH-CA (\$64.00 X 31.75 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2,032.00
			\$3,312.00

#### 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 did prevail on the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$3,312.00.

Based on review of the disputed issues within the request, the Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by Medical Dispute Resolution.

CPT code 97545-WH-CA from 3-1-05 – 3-11-05 was denied by the carrier as "F-Payment for interdisciplinary programs not accredited by CARF are reduced 20% below the maximum allowed reimbursement for that program." This provider is CARF accredited and billed as such. Per Rule 134.202 (e)(5)(C)(ii) reimbursement is \$64 per hour. Recommend additional reimbursement of \$102.40.

CPT code 97546-WH-CA from 3-1-05 – 3-11-05 was denied by the carrier as “F-Payment for interdisciplinary programs not accredited by CARF are reduced 20% below the maximum allowed reimbursement for that program.” This provider is CARF accredited and provided AMS 1500’s supporting this. Per Rule 134.202 (e)(5)(C)(ii) reimbursement is \$64 per hour. Recommend additional reimbursement of \$204.80.

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

28 Texas Administrative Code Sec. 133.308, Rule 134.202(c)(1) and 134.202 (e)(5)(C)(ii).

**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 reimbursement in the amount of \$3619.20. 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:

4-19-06

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

April 12, 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 #: M5-06-1125-01  
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 tripped over a pole and injured his right knee while twisting his upper and lower body. The patient completed seven sessions of work hardening and an orthopedic consultation determined that the patient required surgical intervention on the right knee. Right knee surgery was performed on 04/05/2005.

#### Requested Service(s)

Work hardening program (97545-WH-CA, 97546-WH-CA) from 05/26/05 to 06/13/2005

#### **Decision**

It is determined that the work hardening program (97545-WH-CA, 97546-WH-CA) from 05/26/05 to 06/13/2005 was medically necessary to treat this patient's condition.

#### Rationale/Basis for Decision

A post-operative evaluation was performed on 04/21/2005. Post-operative rehabilitation utilizing active therapy was begun. Another functional capacity evaluation (FCE) performed on 05/17/2005 determined he had limited but good response from active therapy and that he was a good candidate for a work hardening program. He was placed in a work hardening program with final FCE performed on 06/16/2005. He was released to return to work without restrictions. He was placed at maximum medical improvement on 06/17/2005 with a permanent impairment rating of 4%.

Treatment guidelines allow for this type of treatment for this type of injury. There is sufficient documentation on each date of service to clinically justify the work hardening program. The goal of returning the patient to unrestricted full duty employment was met as a direct result of his participation in the aggressive work hardening program. Without such a program it is highly unlikely that he could have returned to a heavy job classification after his knee surgery.

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,

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

Information Submitted to TMF for Review

Patient Name: \_\_\_\_ Tracking #: M5-06-1125-01

**Information Submitted by Requestor:**

- MDR Request
- Report of the MRI scan of the right knee
- WC/WH Program Daily Notes
- Visit Log Reports
- Psychology Group Notes
- Case Management Summaries
- Active Rhab Exercise/FEE Slips
- Notes
- Report of Medical Evaluation
- Right Lower Extremity Impairment Evaluation Record
- Impairment Rating
- Consultative Exam and Impairment Rating
- History and Physical
- Interim functional capacity evaluation (FCE)
- REHAB 2112 Program Policies
- Status FCE
- Initial FCE
- Stress and Lifestyle-Change Survey
- Comprehensive Patient Examination Re-eval
- Recommended treatment plan
- Joint Integrity Test
- Work Program Participant Intake Sheets
- Summary of Maximal Physical Job Demands
- Diagnosis and Treatment Sheets
- Initial Physical Examination
- Report of x-rays of right knee
- Daily progress notes

**Information Submitted by Respondent:**