



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:	MDR Tracking No.: M5-06-1217-01
Horizon Health % Bose Consulting, L. L. C. P. O. Box 550496 Houston, Texas 77255	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
Wausau Underwriter's Insurance Company, Box 28	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 treatment provided for the claimant was medically reasonable and necessary."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response. Position summary states, "Not medically necessary per peer review."

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)
7-1-05 - 9-16-05	CPT code 97110 (\$35.86 X 127 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$4,554.22
7-1-05 - 9-16-05	CPT code 97140 (\$33.91 X 22 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$746.02
7-1-05 - 9-16-05	CPT code 97112 (\$36.75 X 22 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$808.50
7-1-05 - 9-16-05	CPT code 99212 (\$48.03 X 7 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$336.21
7-1-05 - 9-16-05	CPT code 99212 (9 DOS)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
Grand Total			\$6,444.95

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 \$6,444.95.

Services from 6-28-05 through 6-29-05 and CPT code 99212 on 7-1-05 were reimbursed by the carrier on 3-21-06 with check number 12520334. They will not be a part of this review.

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 \$6,444.95. 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:

5-26-06

Order by:

Margaret Ojeda

5-26-06

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 20, 2006

Corrected Letter May 18, 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 #:M5-06-1217-01
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 she was lifting a resident and heard a crack in her right knee. Over the course of her treatment she has had numerous diagnostic tests, extended therapy, medication, and numerous surgeries. She had a total knee replacement on December 9, 2002. She had been given a home exercise program as well as durable medical equipment. She was placed at maximum medical improvement. She continued to experience ongoing pain and problems

Requested Service(s)

Office visits (99212), therapeutic exercises (97110), manual therapy (97140), neuromuscular re-education (97112) provided from 07/01/05 to 09/16/05

Decision

It is determined that the therapeutic exercises (97110), manual therapy (97140), neuromuscular re-education (97112) provided from 07/01/05 to 09/16/05 were medically necessary to treat this patient's condition. It is also determined that weekly office visits (99212) during the treatment period were medically necessary.

It is determined that the remainder of the office visits (99212) during the treatment period were not medically necessary.

Rationale/Basis for Decision

There is sufficient documentation to clinically justify the treatment received. Her condition was severe and complicated due to several previous surgeries. National treatment guidelines allow for approximately 2 to 4 months of post-operative rehabilitation for the surgery she received. Due to the significance of her complicated injury, she needed an aggressive rehabilitative program. Manual therapy (97140), therapeutic exercises (97110) and neuromuscular re-education (97112) during the dates above were necessary for treatment of this patient's medical condition. Guidelines do not allow for an office visit (99212) on each date of service. It has been determined that one office visit (99212) weekly is sufficient to properly manage the case during a treatment program.

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 #: M5-06-1217-01

Information Submitted by Requestor:

None

Information Submitted by Respondent:

Chiropractic Modality Review
Retrospective Review
Billing Retrospective Review
Letters from Dr. Reuben
Horizon Health Notes
Operative Reports
Patient Medical Records
Report of CT scan of right knee
Initial Patient Consultation
Letters from Dr. Xeller
X-ray report of right knee
Psychotherapy Group Session Notes
Functional Capacity Evaluation
Biofeedback Session Notes
Individual Session Notes
Horizon Health Progress Reports
Examination Report
Report of post-arthrogram right knee MRI
Letter from Dr. Albina
Product information
Report of MRI of the right knee
Report of Impairment and Functional Assessment
Discharge functional capacity evaluation.
Functional Capacity Evaluations
Harrisburg Rehabilitation Center weekly conference reports
Examination Reports from Dr. Rodriguez
Psychodiagnostic Examination
Work Hardening Progress Notes
Independent Medical Examination