



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:

Kingwood Occupational and Physical Therapy
23780 Hwy 59 N
Kingwood TX 77339

MDR Tracking No.: M5-06-1260-01

Claim No.:

Injured Worker's Name:

Respondent's Name and Address:

Texas Mutual Insurance Box 54

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DWC-60 package. Position Summary: Medically necessary.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Response to DWC-60 package. Position Summary: Carrier requests that this request be conducted under the provisions of the APA under subsection (k) of the Labor Code Section 413.031.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
7-5-05 to 9-19-05	97110 \$32.27 (<MAR) x 73 units =	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2355.71
	97035 \$14.62 (<MAR) x 19 units =	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$277.78
	97140 \$30.55 (<MAR) x 34 units =	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1038.70
	97504 \$36.58 (<MAR) x 1 day =	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$ 36.58
	97004 \$57.21 (<MAR) x 3 days =	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$171.63
	Total		\$3880.40

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 disputed medical necessity issues.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

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 \$3880.40. 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.

Ordered by:

Medical Dispute Officer

5-11-06

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.

IRO America Inc.

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

May 9, 2006

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

Patient:
TDI-DWC #:
MDR Tracking #: M5-06-1260-01
IRO #: 5251

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

IRO America 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; the Reviewer is a credentialed Panel Member of IRO America's Medical Knowledge Panel who is a licensed Provider, board certified and specialized in Chiropractic Care. The reviewer is on the DWC Approved Doctor List (ADL).

The IRO America 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, records from the Requestor, Respondent, and Treating Doctor(s), including: Notification of IRO Assignment; DTI form MR—117; 10-pages DTI-60; 9-pages EOBs totaling \$2,370.00; 2-pages Karen Griggs OTR, CHT Request for Reconsideration letter; Script for therapy from Christopher Livingston, MD dated 6-3-05, 7-14-05; 2-pages Evaluation by Karen Griggs dated 6-17-05; Re-evaluation dated 7-21-05, 2-pages 8-22-05, 9-19-05; 4-pages Treatment Log; Final Discharge Summary dated 10-12-05; Daily Soap Notes dated 9-19-05, 9-14-05, 9-7-05, 9-6-05, 8-31-05, 8-29-05, 8-24-05, 8-22-05, 8-19-05, 8-17-05, 8-11-05, 8-10-05, 8-9-05, 8-5-05, 8-2-05, 8-1-05, 7-29-05, 7-27-05, 7-25-05, 7-21-05, 7-20-05, 7-18-05, 7-15-05, 7-13-05, 7-12-05, 7-8-05, 7-6-05, 7-5-05, 7-1-05, 6-29-05, 6-27-05, 6-24-05, 6-22-05, 6-24-05, 6-17-05.

CLINICAL HISTORY

The Patient apparently sustained a work related injury on _____, while working for _____. He apparently sustained a crush injury to the left hand resulting in a ray amputation of the index finger, extension repair to the middle finger, and minor repair to the ring finger, fracture dislocation to the thumb and K-wire pinning. He began therapy on 6-17-2005 through a referral from Dr. Chris Livingston, who ordered a static progressive/dynamic flexion and extension splint for the middle finger to be worn during the day as well as hand therapy 3x a week for 4 weeks. The Patient was initially off work and returned during the course of therapy with restrictions.

He underwent a re-evaluation on 7-21-2005, 8-22-2005, and 9-19-2005. The Patient was discharged to home exercise program on 9-19-2005.

DISPUTED SERVICE(S)

Under dispute is the retrospective medical necessity of manual therapy technique 97140, therapeutic exercises 97110, ultrasound 97035, occupational therapy re-evaluation 97004, orthotics fitting 97504 for the dates 6/22/05 through 9/19/05.

DETERMINATION/DECISION

The Reviewer disagrees with the determination of the insurance company.

RATIONALE/BASIS FOR THE DECISION

Based on the clinical evidence and documentation, The Reviewer concluded that The Patient progressed under the current treatment from 6-22-2005 to 9-19-2005. The Patient was able to return to work as a result of the treatment rendered. The Patient demonstrated increased ROM and strength during the 3 month course of treatment.

Screening Criteria

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

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

As an officer of IRO America Inc., I certify that there is no known conflict between the Reviewer, IRO America and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

IRO America is forwarding by facsimile, a copy of this finding to the DWC.

Sincerely,
IRO America Inc.



Dr. Roger Glenn Brown
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 to DWC via facsimile, on this 9th day of May, 2006.

Name and Signature of IRO America Representative:

Sincerely,
IRO America Inc.



Dr. Roger Glenn Brown
President & Chief Resolutions Officer