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: Ergonomic Rehabilitation of Houston 283 Lockhaven Drive, Suite 315 Houston, TX 77073	MDR Tracking No.: M5-06-1288-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: TX Mutual Insurance Company, Box 54	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, "Our services not only fell within the parameters of the Official Disability Guidelines, they actually are 17% less than recommended by the Official Disability Guidelines for this injury."

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)
3-2-05 – 7-8-05	CPT code 97110 ($35.86 X 57 units)	☒ Yes ☐ No	$2,044.02
3-2-05 – 7-8-05	CPT code 97002 ($51.24 X 2 units)	☒ Yes ☐ No	$102.48
	Grand Total		$2,146.50

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 $2,146.50.

Regarding CPT code 97110 on dates of service 4-26-05, 4-28-05, 5-2-05, 5-3-05 and 5-4-05: the carrier did not pay per Rule 134.202(c)(1). Additional reimbursement in the amount of $70.40 is recommended for these dates of service.

In a letter dated the requestor withdrew date of service 5-13-05. This service will not be a part of this review.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and Rule 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 reimbursement in the amount of $2,145.18. 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	5-3-06
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.

Specialty Independent Review Organization, Inc.

May 1, 2006

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

Patient:
DWC #:
MDR Tracking #: M5-06-1288-01
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The 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 Doctor of Chiropractic with a specialty in Rehabilitation. 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

___ was injured while working with HCL Services, LLC on November 17, 2004. The records indicate that Mr. ___ tripped on a pipe and ruptured his achilles tendon. His tendon was surgically repaired on 12/3/04 by Todd Siff, MD. He was provided with an FCE on 3/1/05 and began his rehabilitation program at that point. He completed therapy on or about 7/8/05. He was given a 0% impairment by his treating doctor.

RECORDS REVIEWED

Records were received from the respondent, requestor and the treating doctor. Records from the respondent include the following: 4/25/06 letter by La Treace Giles, RN, 11/17/04 initial medical report, 11/18/04 report by Todd Stiff, MD, 11/29/04 left ankle MRI, 12/3/04 operative report, 3/1/05 rehab evaluation by ErgoRehab, rehab program notes from 3/11/05 through 7/8/05 and TWCC 69 and report of 7/12/05.

Records from the treating doctor include the following (not including those previously mentioned): 6/10/05 progress note

Records from the requestor include the following: 4/19/06 letter from Steven Sopher, PT, MDR paperwork (TWCC 60 and attachments), Medicare Newsletter of 3/1/05 and 11/8/05 and Work loss data institute disability guidelines.

DISPUTED SERVICES

The services under dispute include 97110 therapeutic exercises and 97002-25 (-59) PT re-evaluation from 3/2/05 through 7/8/05.

DECISION

The reviewer disagrees with the previous adverse determination.

BASIS FOR THE DECISION

The reviewer basis this opinion on multiple sources which indicate that the average time for an achilles tendon surgical repair is approximately 4-6 months. According to Brotzman, it may take up to eighteen months of treatment to regain full function. According to Maxey, early postoperative motion minimizes the deleterious effects of immobilization, which is necessary following tendon repair. The rehabilitation program was begun approximately 12 weeks post-surgically. The program was consistent with a progressively difficult protocol throughout the length of treatment. All of his ROM's were increased throughout treatment and his functional abilities improved. This qualifies for treatment as per TLC 408.021 and per accepted rehabilitation protocols.

REFERENCES

Brotzman S Wilk K Clinical Orthopaedic Rehabilitation, Second Edition, Mosby 2003, p 410-12.

Maxey L Magnusson J Rehabilitation for the Postsurgical Orthopedic Rehabilitation Patient, Mosby 2001, p 330-340.

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 TDI/DWC- Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the DWC via facsimile, U.S. Postal Service or both on this 1st day of May 2006

Signature of Specialty IRO Representative:
Name of Specialty IRO Representative: Wendy Perelli