



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 Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier

Requestors Name and Address: Valley Spine Medical Center 5327 South McColl Road Edinburg, Texas 78539	MDR Tracking No.: M5-06-1439-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: MGMT FUND Rep Box # 47	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: Per the Table of Disputed Services "The care rendered to the patient has met criteria set by Texas Labor code section 408.21 complete rationale for increase reimbursement can be found in the medical records of the complete Medical Dispute."

Principle Documentation:

1. DWC-60/Table of Disputed Services
2. CMS 1500's
3. Explanation of benefits

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: Per the Table of Disputed Services "Documentation failed to support the need for tx of this type or length."

Principle Documentation: Response to DWC-60

PART IV: SUMMARY OF DISPUTE AND FINDINGS

<u>Date(s) of Service</u>	<u>CPT Code(s) or Description</u>	<u>Medically Necessary?</u>	<u>Additional Amount Due (if any)</u>
04-25-05 to 08-22-05	97110 (1 unit @ \$33.56 X 71 units) 99212 (\$45.26 X 3 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2,382.76 \$135.78
	<u>TOTAL</u>		\$2,518.54

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

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

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 reimbursement in the amount of \$2,518.54. In addition, the Division finds that the Requestor was the prevailing party and is entitled to a refund of the IRO fee \$460.00. The Division hereby **ORDERS** the Respondent 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:

08-01-06

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.

INDEPENDENT REVIEW INCORPORATED

June 29, 2006

Re: MDR #: M5 06 1439 01 Injured Employee: ___
DWC #: ___ DOI: ___
IRO Cert. #: 5055 SS#: ___

TRANSMITTED VIA FAX TO:

TDI, Division of Workers' Compensation

Attention: ___

Medical Dispute Resolution

Fax: (512) 804-4868

RESPONDENT: TASB

REQUESTOR: Valley Spine Medical Center

TREATING DOCTOR: Alex Flores, DC

In accordance with the requirement for DWC to randomly assign cases to IROs, DWC assigned this case to IRI for an independent review. IRI has performed an independent review of the medical records to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the office manager of Independent Review, Inc. and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him 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 Independent Review Organization. Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a chiropractor who is currently listed on the DWC Approved Doctor List.

We are simultaneously forwarding copies of this report to the payor and the TDI, Division of Workers' Compensation. This decision by Independent Review, Inc. 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, 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.

Sincerely,

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Jeff Cunningham, DC
Office Manager

INDEPENDENT REVIEW INCORPORATED

REVIEWER'S REPORT

Information Provided for Review:

1. DWC Assignment
2. Carrier records
3. Valley Spine Medical Center, PA records
4. MRI and X-ray reports
5. Surgical History

Clinical History:

The patient was injured on his job with the _____ when he was walking children through a crosswalk on a street and mis-stepped on a curb, causing him to twist his right ankle and knee. He complained of pain in his right knee and ankle. X-rays of the knee and ankle were negative for pathologies. MRI was performed on April 4, 2005 and he was found to have a meniscus tear in the right knee. He underwent arthroscopic surgery on June 2, 2005 by Dr. Guillermo Pechero.

Decision:

I DISAGREE WITH THE DETERMINATION MADE BY THE UTILIZATION REVIEW AGENT ON THIS CASE.

Disputed Services:

The carrier has denied the medical necessity therapeutic exercises and office visits from April 25, 2005 to August 22, 2005.

Rationale:

There is no doubt that this patient was injured on his job and that the injury was serious enough to require surgery. The office notes indicate that the patient did indeed benefit from the office visits to Valley Spine and that he continued to make progress through the therapy. Certainly an injury that requires surgery will also require a certain amount of therapy and one must be careful in the balance of whether we go one direction or the other in being too conservative or too liberal with the treatment rendered. However, the treatment on this case did seem to benefit the patient and to give the patient the benefit of the doubt is appropriate in this case. As a result, the care rendered is reasonable and necessary.

Screening Criteria/Studies

TCA Guidelines, Guidelines of the Mercy Conference.