



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: Total Rehab of Harlingen 1327 E. Washington Ave PMB 143 Harlingen, Texas 78550	MDR Tracking No.: M5-06-1487-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: TPS Joint Self Insurance Funds Rep Box # 42	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60
POSITION SUMMARY: Per the Table of Disputed Services "Medically necessary – Insurance inconsistent with denials and the denial reasons are incorrect".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DWC-60
POSITION SUMMARY: None submitted by Respondent

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	DOCUMENTATION SUBMITTED: Response t CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
09-19-05 to 11-01-05	97110 (with the exception of DOS listed below), 97112, 97026, 97113, A456 and 97750-FC-GP	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
09-19-05	97110 (1 unit)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$33.56
09-20-05 & 09-22-05	97110 (2 units @ \$67.12 X 2 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$134.24
TOTAL			\$167.80

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 **not** prevail on the **majority** of the disputed medical necessity issues.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 134.202

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 \$167.80. In addition, the Division finds that the requestor was not the prevailing party and is not entitled to a refund of the IRO fee. 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.

Order by:

06-19-06

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.



IMED, INC.

1819 Firman • Suite 143 • Richardson, Texas 75081
Office 972-381-9282 • Toll Free 1-877-333-7374 • Fax 972-250-4584
e-mail: imeddallas@msn.com

NOTICE OF INDEPENDENT REVIEW

NAME OF EMPLOYEE: _____
IRO TRACKING NUMBER: M5-06-1487-01
NAME OF REQUESTOR: Total Rehab of Harlingen
RESPONDENT: Harris & Harris
TREATING DOCTOR: Cynthia A. Garcia, M.D., P.A.
NAME OF CARRIER: Texas Political Subdivisions
DATE OF REPORT: 06/06/06
DATE OF AMENDED REPORT: 06/12/06
IRO CERTIFICATE NUMBER: 5320

TRANSMITTED VIA FAX TO:

IMED, Inc. has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO).

In accordance with the requirement for TDI to randomly assign cases to IROs, TDI has assigned your case to IMED, Inc. for an independent review. The peer reviewer selected has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, the peer reviewer reviewed 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.

The independent review was performed by a matched peer with the treating physician. This case was reviewed by an M.D. physician reviewer who is Board Certified in the area of Physical Medicine & Rehabilitation and is currently listed on the DWC approved doctor list.

I am the Secretary and General Counsel of IMED, 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 provider, the injured employee, 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. I further certify that no conflicts of interest of any nature exist between any of the aforementioned parties and any director, officer, or employee of IMED, Inc.

REVIEWER REPORT

I have reviewed the records forwarded on the above injured worker and have answered the questions submitted.

Information Provided for Review:

- Table of disputed services.
- Physical therapy notes Total Rehab of Arlington from 09/14/05 to 10/28/05.
- General examination with FCE 11/01/05.
- Forte review findings 11/21/05.
- Forte re-review bills 02/21/06.
- RME dated 05/11/06 from John Westkemper, M.D.

Clinical History Summarized:

The employee was injured on ____.

The injured employee was seen for a therapy evaluation on 09/14/05. Previously she had a fifth metatarsal fracture of the right foot and underwent an open reduction/internal fixation on the fifth metatarsal fracture. Casting was removed on 09/13/05.

The employee retired from her job with at the _____ where she had worked but would like to return in a teaching or secretarial position as soon as she was cleared by her doctor.

The employee participated in a supervised therapy program during September, 2005. She continued with the supervised therapy program during October, 2005.

The employee was seen for a therapy reevaluation on 10/07/05. Initially, she was walking with a rolling walker independently with difficulty. The employee continued with a rolling walker and had minimal pain in her gait. She remained partially bearing with a discharge on 10/28/05. Her final level was no assisted device and independent difficulty of 100 feet.

A Functional Capacity Evaluation (FCE) was performed on 11/01/05. The employee was classified at the light to medium physical demand level.

Bill review findings were done by Joe Wilk, M.D., on 11/21/05 and by Hoang Tran, M.D., on 02/21/06.

Disputed Services:

Therapeutic exercises (97110), neuromuscular reeducation (97112), application modality one or more areas – infrared (97026), aquatic therapy (97113), electrodes (A4556), Functional Capacity Evaluation (97750-FC-GP), and dates of service 09/19/05 to 11/01/05.

Decision:

Based upon the records reviewed, the employee may have required a therapeutic exercise program not to exceed three visits with a goal of transitioning to a home exercise program. Although she underwent surgical intervention for a fifth metatarsal fracture, she would not require ongoing treatment including neuromuscular reeducation (97112), application modality one or more areas – infrared (97026), aquatic therapy (97113), electrodes (A4556), or FCE (97750-FC-GP). Clearly this individual has retired. The need for an FCE is not considered reasonable as it relates to the work event of ____.

Therefore, only three sessions of a therapeutic exercise program with the goal of transitioning to a home exercise program would be reasonable and necessary.

Rationale/Basis for Decision:

This opinion is based upon the Official Disability Guidelines as a reference.

The rationale for the opinion stated in this report is based on the record review, as well as the broadly accepted literature to include numerous textbooks, professional journals, nationally recognized treatment guidelines and peer consensus.

This review was conducted on the basis of medical and administrative records provided with the assumption that the material is true and correct.

This decision by the reviewing physician with IMED, Inc. is deemed to be a DWC decision and order.

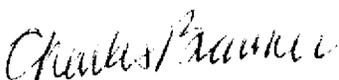
YOUR RIGHT TO REQUEST A HEARING

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 thirty (30) days after the date on which the decision that is the subject of the appeal is final and appealable.

I hereby verify that a copy of this Independent Review Organization's decision was sent to DWC via facsimile or U.S. Postal Service this 7th day of June, 2006 from the office of IMED, Inc.

Sincerely,



Charles Brawner
Secretary/General Counsel