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: Rehab Affiliates, Inc 915 Huebner Road, Suite 340 San Antonio, Texas 78240	MDR Tracking No.: M5-06-1504-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: AMCOMP Assurance Corporation Rep Box # 34	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60 dispute package
POSITION SUMMARY: Per the table of disputed services "the patient meets criteria for continued therapy".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60
POSITION SUMMARY: "Upon review of the attached documentation and that found within the carrier's file, reimbursement for the services outlined in this dispute will continue to be denied. Denial is based on the Medicare utilization guidelines for physical medicine".

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
09-30-05 to 11-29-05	97110, 97112, G0283, 97032, 97116, 97140 and 97002	☐ Yes ☒ No	$0.00

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 disputed medical necessity issues.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308

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 Division has determined that the requestor is not entitled to reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

Authorized Signature	Typed Name	Date of Findings and Decision
		06-02-06

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.

MEDICAL REVIEW OF TEXAS

[IRO #5259]
10817 W. Hwy. 71 Austin, Texas 78735
Phone: 512-288-3300 FAX: 512-288-3356

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	
MDR Tracking Number:	M5-06-1504-01
Name of Patient:	
Name of URA/Payer:	Rehab Affiliates Inc
Name of Provider: (ER, Hospital, or Other Facility)	Rehab Affiliates Inc
Name of Physician: (Treating or Requesting)	Martin Chaney, MD

May 26, 2006

An independent review of the above-referenced case has been completed by a physician board certified in neurology. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on the Division of Workers' Compensation Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Division of Workers' Compensation

DOCUMENTS REVIEWED
Notification of IRO assignment. Initial post-injury evaluation done on the date of injury (___) by Benton P. Zwart, MD, as well as follow up visits by Dr. Zwart from Concentra Medical Centers. Evaluations from Martin Chaney, DPM. Physical therapy reports and evaluations from Rehab Affiliates. MRI or right ankle without contrast, Radiology Associates of San Antonio, PA 07/18/05.

CLINICAL HISTORY
A 34-year old male who, along with fellow employees, was helping to push a hydraulic bender machine when it shifted and rolled over his right foot, ankle, and distal lower leg. Noted on initial examination to have superficial abrasion of the distal tibial region and proximal lateral superior ankle without ecchymosis or bleeding. There was mild swelling at

the lateral inferior right malleolus to anterior forefoot with pain on inversion. There was ecchymosis over the dorsal-lateral aspect of the forefoot with tenderness to the palpation on the posterior plantar foot. The patient has complained of continued and worsening pain in this region and inability to bear weight on his right foot. The patient was noted at physical therapy in Concentra Medical Centers on 06/28/05 to be "guarding against mobilization of PROM of right ankle specifically talo-crural joint. Therapist observes patient walking to vehicle with heel to toe progression with bilaterally axillary crutches with minimal limitations in stance, time or WB on R LE. ROM in right ankle and toes has worsened. There is minimal motion of right foot last digit. The patient is insistent that his is trying to move toes without success.

REQUESTED SERVICE(S)
Therapeutic exercises, neuromuscular re-education, electrical stimulation G0283, 97032, gait training 97116, manual therapy technique 97140, physical therapy re-education 97002 from 09/30/05 to 11/29/05 medically necessary.

DECISION
Denied.

RATIONALE/BASIS FOR DECISION
The patient had only a mild to mild-moderate, at most, injury. By any measures this should have resolved within six to eight weeks. There were no abnormalities demonstrated on multiple x-rays. Injuries reported on examination were mild. In deed, when an MRI scan was performed, there were no boney or ligamentous or musculature injuries defined at that time either. There were obviously nonorganic findings noted by there physical therapist at Concentra Medical Center on their report of service date 06/28/05. There is obvious symptom magnification present.

Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that I have no known conflicts of interest between the 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.

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.

Chief Clerk of Proceedings
Division of Workers' Compensation
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Marc Salvato