



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:	MDR Tracking No.: M5-06-1591-01
Horizon Health % Bose Consulting, L. L. C. P. O. Box 550496 Houston, Texas 77255	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Box 29	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, "The above indicates that the treatment provided for the claimant was medically reasonable and necessary. We are requesting reimbursement for all disputed dates of services."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No DWC 60 response.

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)
5-2-05 – 8-18-05	CPT code 99212 (\$49.41 X 48 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2,371.68
5-2-05 – 8-18-05	CPT code 97110 (\$35.86 X 288 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$10,327.68
5-2-05 – 8-18-05	CPT code 97112 (\$37.77 X 48 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,812.96
5-2-05 – 8-18-05	CPT code 97140 (\$33.93 X 48 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,628.64
5-2-05 – 8-18-05	CPT code 99080-73 (\$15.00 X 3 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$45.00
	Total		\$16,185.96

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 disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$16,185.96.

In accordance with Rule 133.308 (e), requests for medical dispute resolution are considered timely if they are filed with the division no later than one year after the dates of service in dispute. The following dates of service are not eligible for this review: 4-6-05 – 4-28-05.

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 \$16,185.96. 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 by:

7-7-06

Order by:

Medical Dispute Resolution

7-7-06

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.

NOTICE OF INDEPENDENT REVIEW DECISION

June 22, 2006

Program Administrator
Medical Review Division
Division of Workers Compensation
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Claim #:
Injured Worker:
MDR Tracking #: M5-06-1591-01
IRO Certificate #: IRO4326

TMF Health Quality Institute (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Division of Workers' Compensation (DWC) has assigned the above referenced case to TMF for independent review in accordance with DWC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, 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 was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and the provider, 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. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient sustained a work related injury on _____. There was a floor that was being mopped and was wet with too much water on the floor. She slipped and fell backwards, twisting her left leg and falling onto her left side causing her injuries. This resulted in complaints of pain in the back, left hip, and left knee. The patient has undergone chiropractic treatments, medication, and treatment with a pain management specialist.

Requested Service(s)

(99212) office visits, (97110) therapeutic exercises, (97140) manual therapy technique, (97112) neuromuscular reeducation, and (99080-73) report provided from 05/02/05 through 08/18/05.

Decision

It is determined that the (99212) office visits, (97110) therapeutic exercises, (97140) manual therapy technique, (97112) neuromuscular reeducation, and (99080-73) report provided from 05/02/05 through 08/18/05 were medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient had multiple injured areas and required more treatment than would be needed for a single injured area. The records indicated she had progressed through the active treatment program. There is sufficient documentation on each date of service to clinically justify the services rendered. Her condition was managed by an orthopedic specialist, a pain management specialist and her treating doctor. The diagnostic testing confirmed the extent of her injuries. She responded well to the treatment she received and on 08/18/05 her VAS pain level in her left knee was a 3/10 where it had previously been 6/10. The records demonstrated the patient's ability to complete the assigned tasks without significantly increasing the pain level. The designated doctor examination on two occasions found that she was not at maximum medical improvement.

The records do provide the necessary documentation to allow for this type of treatment for this type of injury. The above stated treatments were medically necessary based on the reviewer's clinical experience in conjunction with the guidelines from The American Academy of Physical Medicine and Rehabilitation, North American Spine Society, American College of Occupational and Environment Medicine (ACOEM), and Official disability Guidelines (EDG).

This decision by the IRO 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 (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,

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:dm

Information Submitted to TMF for Review

Patient Name: ____ Tracking #: M5-06-1591-01

Information Submitted by Requestor:

- Position Statement
- MRI report of left knee
- MRI of lumbar spine
- Nerve Conduction Study and Electromyography Report
- Office notes from Dr. Pervez
- Office notes from Dr. Reuben
- Office notes from Dr. English
- Office notes from Dr. Schwartz
- Daily notes from Horizon Health

Information Submitted by Respondent:

None