



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:
Texas Workers Rehab
9400 N. Mac Arthur Blvd. # 130
Irving, Texas 75063

MDR Tracking No.: M5-06-1642-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:
American Home Assurance
Rep Box # 19

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 "medical necessity present."

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: "...Carrier concludes fair & reasonable payment made to provider, per standard & established protocol; with correct exception codes, & adequate additional explanation."

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>
05-02-05 to 05-20-05	97545-CA-WH (1 unit @ \$128.00 X 11 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,408.00
	97546-CA-WH (5 units @ \$320.00 X 5 DOS)		\$1,600.00
	97546-CA-WH (4 units @ \$256.00 X 3 DOS)		\$768.00
	97546-CA-WH (6 units @ \$384.00 X 2 DOS)		\$768.00
	97546-CA-WH (3 units @ \$192.00 X 1 DOS)		\$192.00
	<u>TOTAL DUE</u>		\$4,736.00

P.O. Box 855
Sulphur Springs, TX 75483
903.488.2329 * 903.642.0064 (fax)

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.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.1 and 134.202
Texas Labor Code, Sec. 413.031 and 413.011 (a-d)

PART VII: DIVISION FINDINGS 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 \$4,736.00. In addition, the Division finds that the Requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of \$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.

Order by:

09-05-06

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

August 28, 2006

Re: MDR #: M5 06 1642 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: ARCFMI

REQUESTOR: Texas Worker's Rehab

TREATING DOCTOR: Greg Bunting, 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.

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,

Jeff Cunningham, DC
Office Manager

INDEPENDENT REVIEW INCORPORATED

REVIEWER'S REPORT M5 06 1642 01

Information Provided for Review:

1. DWC Assignment
2. Carrier records
3. Treating doctor records
4. Diagnostic reports
5. Surgical reports

Clinical History:

The patient was injured on her job with Wal-Mart stores when she sustained a slip and fall that caused her to injure her neck, mid back, low back and left lower extremity. She eventually was diagnosed with a torn medial meniscus on the left. She underwent left knee arthroscopy in September of 2004 by Dr. John McConnell. After initial rehabilitation, she was sent for work hardening at Texas Workers' Rehab.

Disputed Services:

The carrier denies the medical necessity of work hardening from May 2, 2005 through May 20, 2005

Decision:

I DISAGREE WITH THE CARRIER'S DECISION IN THIS CASE.

Rationale:

This patient did suffer injuries which required surgical intervention and the injuries were extensive enough to prevent her from performing her duties, as documented by the requestor. While not all cases that require surgery should be sent for work hardening, this case clearly qualifies as a case that would be appropriate due to the history of the case and the patient's debilitated condition after surgery.

Screening Criteria/Guidelines:

Mercy Center Guidelines, North American Spine Society Phase III