



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

PART I: GENERAL INFORMATION

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

Requestors Name and Address: Rehab 2112 P. O. Box 671342 Dallas, TX 75267	MDR Tracking No.: M5-06-1687-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: New Hampshire Insurance Company, Box 19	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, "Services were medically necessary."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No DWC 60 response received.

PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

<u>Date(s) of Service</u>	<u>CPT Code(s) or Description</u>	<u>Medically Necessary?</u>	<u>Additional Amount Due (if any)</u>
9-2-05 – 9-20-05	CPT code 97545-WH-CA (1 unit @ \$128.00 X 10 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,280.00
9-2-05 – 9-20-05	CPT code 97546-WH-CA (\$64.00 X 49 units per Rule 134.202 (e)(5)(C)(ii))	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$3,136.00
	Total		\$4,416.00

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 prevail on the majority of the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$4,416.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.202(c)(1) and 134.202 (e)(5)(C)(ii)

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 additional reimbursement in the amount of \$4,416.00. 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 and Order by:

Donna Auby, Medical Dispute Officer

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.



June 29, 2006

Re: MDR #: M5 06 1687 01 Injured Employee: ___
 DWC #: ___ DOI: ___
 IRO Cert. #: 5340 SS#: ___

TRANSMITTED VIA FAX TO:

TDI, Division of Workers' Compensation

Attention: ___

Medical Dispute Resolution

Fax: (512) 804-4868

RESPONDENT: New Hampshire Insurance

REQUESTOR: Rehab 2112

TREATING DOCTOR: Shane Marcum, DC

In accordance with the requirement for DWC to randomly assign cases to IROs, DWC assigned this case to ZRC Medical Resolutions for an independent review. ZRC has performed an independent review of the medical records to determine medical necessity. In performing this review, ZRC 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 president of ZRC Medical Resolutions, 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 physician who is a licensed Doctor of Chiropractic who has greater than 20 years experience in active practice and is on the DWC ADL, Level 2.

We are simultaneously forwarding copies of this report to the payor and the TDI, Division of Workers' Compensation. This decision by ZRC Medical Resolutions, 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
President

REVIEWER'S REPORT M5 06 1687 01

Information Provided for Review:

1. Clinical records from the requestor
2. Clinical records and letter of explanation from carrier's attorney

Clinical History:

Claimant underwent diagnostic imaging and physical medicine treatments after sustaining injury at work on ___ when she was struck on the head by a metal rolling pin, metal pots and pans.

Disputed Services:

Work hardening (97545-WH-CA) and work hardening each additional hour (97546-WH-CA) from 09/02/05 through 09/20/05.

Decision:

The reviewer disagrees with the URA's determination in this case.

Rationale:

In this case, there is adequate documentation of objective and functional improvement in this patient's condition. Specifically, the patient's pain ratings decreased from 5/10 (at the initiation of the disputed treatment on 09/02/05) to 0/10 (at the termination of care on 09/21/05), her cervical ranges of motion increased to normal, her PDC improved to "medium," and she was released to return to work. Therefore, the medical records fully substantiate that the disputed services fulfilled statutory requirements¹ for medical necessity since the patient obtained relief, promotion of recovery was accomplished and there was an enhancement of the employee's ability to return to employment.

Screening Criteria/Literature:

TCA Guidelines to Quality Assurance, Mercy Guidelines, TMF Guidelines

¹ Texas Labor Code 408.021