



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

Requestor's Name and Address: Whigham Chiropractic 2646 S. Loop West # 290 Houston, Texas 77054	MDR Tracking No.: M5-06-1711-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Liberty Mutual Fire Insurance Rep Box # 28	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: "The Insurance Carrier denied parts of the treatment stating 'Based on Peer Review further treatment is not necessary' However, they then later paid for the Work Hardening program. Again the peer review should not be considered in past or future treatment."

Principle Documentation:

1. DWC-60/Table of Disputed Services
2. Explanation of Benefits

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: Per the Table of Disputed Services "denied per Peer Review."

Principle Documentation:

1. 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>
06-02-05 to 09-06-05	99211 (\$27.49 X 14 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$384.86
06-06-05 to 08-30-05	97110 (1 unit @ \$35.00 X 15 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$525.00
06-13-05	97110 (1 unit @ \$35.00 X 2 = \$70.00 X 1 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$70.00
08-25-05	97750-FC (1 unit @ \$38.25 X 2 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$76.50

	TOTAL DUE		\$1,056.36
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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.

Per Rule 133.308(e)(1) dates of service 02-04-04 through 05-24-05 listed on the Table of Disputed Services were not timely filed and will not be a part of the review.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.1 and 134.202(c)(1) and 134.202(d)(2)
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 \$1,056.36. 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:

09-15-06

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 15, 2006

Re: **MDR #:** **M5 06 1711 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: **Liberty Mutual**

TREATING DOCTOR: **Gwendolyn Whigham, 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 licensed Doctor of Chiropractic 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,

The initials 'JC' are rendered in a large, bold, serif font. The 'J' is lowercase and the 'C' is uppercase. The letters are black and have a classic, slightly ornate design.

Jeff Cunningham, DC
Office Manager

INDEPENDENT REVIEW INCORPORATED

REVIEWER'S REPORT M5 06 1711 01

Information Provided for Review:

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

Clinical History:

This patient was injured on his job while running communication cable. He was moving a sink, made of metal, and apparently experienced an onset of pain in the right shoulder region. He underwent surgery for the rotator cuff tear on October 8, 2004 and also was diagnosed with a SLAP lesion. The patient was involved in an automobile accident which re-injured his low back in ___, which was adjudged to be part of the original injury in a DWC finding of .

Disputed Services:

The carrier has denied the medical necessity of therapeutic exercises, office visits and FCE.

Decision:

I DISAGREE WITH THE DETERMINATION MADE BY THE UTILIZATION REVIEW AGENT ON THIS CASE.

Rationale:

While there has been a lot of treatment on this case, it has also been delayed and denied due to the compensability issues of the DWC. Also, the treatment that is in dispute is fairly minimal and was a direct result of a re-injury, as found by the DWC. The care certainly seems to be within standards of care of the chiropractic practice and would be considered reasonable considering the circumstances of the multiple areas of injury as well as the denial of the compensability of the care. Consulting surgeons on this case generally agreed with the physical medicine being rendered on the patient, as well. Due to this, I believe that the care was reasonable and necessary.

Screening Criteria/Guidelines Used:

CA Guidelines, Guidelines of the Mercy Conference.