



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

Requestor's Name and Address:

James Tanner, D. C.
 5350 Staples Ste. 210
 Corpus Christi, Texas 78411

MDR Tracking No.: M5-06-1730-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:

Box 42

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. CMS-1500's
3. EOB's

Position summary states, "Treatment was medically necessary."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation:

1. DWC-60/Table of Disputed Service

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)
7-8-05	97750-FC (\$35.51<MAR x 16 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$568.20
7-8-05	99080-73	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$15.00
			\$583.20

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 \$583.20.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 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 additional reimbursement in the amount of \$583.20. 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:

Medical Dispute Officer

8-01-06

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.

MEDICAL REVIEW OF TEXAS

[IRO #5259]

10817 W. Hwy. 71
Phone: 512-288-3300

Austin, Texas 78735
FAX: 512-288-3356

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	
MDR Tracking Number:	M5-06-1730-01
Name of Patient:	
Name of URA/Payer:	James Tanner, DC
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	James Tanner, DC

July 11, 2006

An independent review of the above-referenced case has been completed by a chiropractic doctor. 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

Available documentation received and included for review consists of initial and subsequent treatment records, including FCE Dr. Tanner (DC), along with position statement and request for reconsideration, Peer review, Dr. Tsourmas (MD), MRI report 05/06/05, TWCC 73.

CLINICAL HISTORY

Ms. ____, a 48 year-old female injured her lower back while in the course of her occupation is a childcare provider. She was bending over, repetitively picking up babies. She was treated by multiple providers, remaining at work. She changed treating doctor to Dr. Garcia, a chiropractor in late 2004. He took her off work (September 2004). MRI obtained in May of 2005 indicated a broad-based disc protrusion at L4/L5. She was then referred to Dr. Tanner, another chiropractor, for a functional capacity evaluation after having been absent from work since September 2004, to more accurately assess her work capabilities prior to a return to work. The FCE was performed in July 2005 and revealed the patient qualified for a return at a medium physical demand level.

REQUESTED SERVICE(S)

Medical necessity of functional capacity exam, (97750-FC) and special report (99080-73) for date of service 7/8/05.

DECISION

Approved.

RATIONALE/BASIS FOR DECISION

The patient had been off work for at least nine months. It is appropriate to accurately determine her work capabilities prior to returning her to the work place, especially after such an extended period of absence. A functional capacity evaluation is a viable assessment to determine such capabilities.

References:

The Work Loss Data Institute's *Official Disability Guidelines, third edition 2005*

The American College of Occupational and Environmental Medicines *Occupational Medicine Practice Guidelines,*

The American Physical Therapy Association *Guidelines for Programs for Injured Worker's,* 1995

CARF Manual for Accrediting Work Hardening Programs

AMA Guides to the Evaluation of Physical Impairment, 4th Edition

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: Cindy Mitchell