



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: Integra Specialty Group, P.A. 517 North Carrier Parkway, Suite G Grand Prairie, Texas 75050	MDR Tracking No.:	M5-06-1734-01
	Claim No.:	
	Injured Employee's Name:	
Respondent's Name and Address: Rochdale Insurance Company Rep Box # 17	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 "Medically Necessary"

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: Per the Table of Disputed Services "recd 97 days (4/3/06) not medically necessary – DD determined to be MMI 0% as of June 2005..."

Principle Documentation: Response to DWC-60

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
02-27-06	97750-FC (1 unit @ \$37.05 X 16 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$592.80
03-28-06	97750-FC (1 unit @ \$37.05 X 8 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$296.40
	TOTAL DUE		\$889.20

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 Requestor submitted a modified table to Medical Dispute Resolution on 07-20-06 disputing code 97750-FC only billed on dates of service 02-27-06 and 03-28-06.

CPT code 99080-73 billed for date of service 12-28-05 was denied by the Respondent with denial codes "18/29/W4" (duplicate claim/service/the time limit for filing has expired/no additional reimbursement allowed after review of appeal/reconsideration). The Respondent has not made a payment. The Respondent submitted proof via e-mail that the claim for the service billed was received on 04-03-06 which was not within the 95 day time limit per Rule 133.20. Reimbursement is not recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.1, 134.202 and 133.20
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 \$889.20. 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:

09-11-06

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.



IMED, INC.

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NOTICE OF INDEPENDENT REVIEW

NAME OF EMPLOYEE:
IRO TRACKING NUMBER: M5-06-1734-01
NAME OF REQUESTOR: Integra Specialty Group, P.A.
NAME OF CARRIER: Rochdale Insurance / Am Trust
DATE OF REPORT: 08/02/06
IRO CERTIFICATE NUMBER: 5320

TRANSMITTED VIA FAX:

IMED, Inc. has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO).

In accordance with the requirement for TDI to randomly assign cases to IROs, TDI has assigned your case to IMED, Inc. for an independent review. The peer reviewer selected has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, the peer reviewer reviewed 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.

The independent review was performed by a matched peer with the treating physician. This case was reviewed by a chiropractic physician reviewer who is Board Certified in the area of Chiropractic Medicine and is currently listed on the DWC approved doctor list.

I am the Secretary and General Counsel of IMED, 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 provider, the injured employee, 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. I further certify that no conflicts of interest of any nature exist between any of the aforementioned parties and any director, officer, or employee of IMED, Inc.

REVIEWER REPORT

I have reviewed the records forwarded on the above injured worker and have answered the questions submitted.

Information Provided for Review:

1. 04/28/05 – Andrew Palafox, M.D.
2. 05/13/05 – Andrew Palafox, M.D.
3. 05/31/05 – Peer review, Phillip Osborne, M.D.
4. 06/22/05 – Ara Robert Dayian, M.D., MRI/Impairment Rating.
5. 08/16/05 – A response letter from Ara Robert Dayian, M.D.
6. 09/23/05 – Medical record review, Benjamin Agana, M.D.
7. 11/01/05 – Required Medical Evaluation, Samuel Bierner, M.D.
8. 02/27/06 – Ergos evaluation summary report.
9. 07/20/06 – IRO position statement.

Clinical History Summarized:

The employee was injured on ___ when she was cleaning a hotel room. She was walking backwards, tripped on some luggage, and fell onto the carpeted floor.

The injured employee was sent back to work with limitations of no lifting over 15 pounds and no bending greater than two times per hour, as well as no pushing/pulling over 15 pounds.

04/28/05 – There was a review by Andrew Palafox, M.D. Dr. Palafox stated the diagnosis was a strain/sprain of the cervical and lumbar spine, and that x-rays of the cervical and lumbar spine would be warranted.

05/13/05 – There was an addendum to Dr. Palafox's review. Dr. Palafox reviewed the initial documentation which indicated that the injured worker was complaining of pain rated at 5/10. It was indicated that occupational therapy was requested. After reviewing the records, Dr. Palafox indicated that the injured employee was six weeks post thoracic sprain/strain, and that she should be able to return to work. A Functional Capacity Evaluation (FCE) was recommended.

05/31/05 – There was a peer review from Phillip Osborne, M.D. Dr. Osborne related the injured worker's medical history and indicated that the complaints of pain would be related to the injury. Dr. Osborne indicated that a course of physical therapy, prescription medications, testing, and office visits were reasonable and necessary. Dr. Osborne also stated that at that time, only maintenance care would be reasonable and necessary, and that current medical literature did not support more than four to six weeks of therapy which the injured employee had already undergone.

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06/22/05 – The injured employee saw Ara Robert Dayian, M.D., who indicated the claimant had a 0% impairment rating and was at Maximum Medical Improvement (MMI).

08/16/05 – There was a response letter from Dr. Dayian. He read the MRI of the cervical and lumbar spine dated 06/27/05. He stated that the lumbar MRI was interpreted as normal, and it did not change his previous opinion.

09/23/05 – Benjamin Agana, M.D. Dr. Agana indicated that there was no indication for additional treatment.

11/01/05 – Samuel Bierner, M.D. Dr. Bierner stated that the extent of injury was a cervical strain and lumbar strain, and that he agreed with the 0% impairment rating.

Disputed Services:

FCE denied for medical necessity.

DOS: 02/27/06 – 03/28/06

Decision:

FCE approved for medical necessity for dates of service 02/27/06 through 03/28/06.

Rationale/Basis for Decision:

On 4/13/05, Dr Palafox recommended a FCE and return to work. The employee was placed at MMI on 06/22/05, but there is no record of any FCE performed indicating return to work status. There was no indication in any pre or post MMI documentation that the employee had the ability to function in her work environment, and based upon the documentation, the employee never returned to work. A FCE was finally performed in February of 2006 to determine ability, and the FCE clearly demonstrated that physical performance versus job requirements did not match. Therefore, the FCE in dispute established a recommendation for work hardening.

A preauthorization request for fifteen sessions of work hardening dated 03/28/06 was approved for work hardening and referenced the “disputed” FCE in the decision. It was very clear the claimant was not working, and the FCE determined there was physical demand level inadequacy in performance versus her job requirements.

Reference material includes the Texas Labor Code, ACOEM Guidelines, and epic lifting information.

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The rationale for the opinion stated in this report is based on the record review, the above mentioned guidelines, as well as the broadly accepted literature to include numerous textbooks, professional journals, nationally recognized treatment guidelines and peer consensus.

This review was conducted on the basis of medical and administrative records provided with the assumption that the material is true and correct.

This decision by the reviewing physician with IMED, Inc. is deemed to be a DWC decision and order.

YOUR RIGHT TO REQUEST A HEARING

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 thirty (30) days after the date on which the decision that is the subject of the appeal is final and appealable.

I hereby verify that a copy of this Independent Review Organization's decision was sent to the DWC via facsimile or U.S. Postal Service this 4th day of August, 2006 from the office of IMED, Inc.

Sincerely,

Charles Brawner
Secretary/General Counsel