



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:	MDR Tracking No.: M5-06-1876-01
North Texas Pain Recovery Center 6702 West Poly Webb Road Arlington, Texas 76016	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
Insurance Company of the State of PA, Box 19	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary states, "Please note that the original claims should have been processed as a complete based on TWCC guidelines, 133.301. Please review this claim based on the TWCC Guidelines... should be reimbursed at DOP. Please review the decision made by your facility."

Principle Documentation:

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

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary states, "Carrier denied the claim because the injury has been adjudicated as non-compensable. It is also doubtful that work hardening would be needed for the diagnosis code used: lumbar strain/sprain."

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)
10-24-05 – 10-28-05	97545-WH-CA	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
10-24-05 – 10-28-05	97546-WH-CA	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
Grand Total			\$0.00

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 not prevail on the disputed medical necessity issues. The amount due the Requestor for the items denied for medical necessity is \$0.00

Based on review of the disputed issues within the request, the Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by Medical Dispute Resolution.

On 8-10-06 the Medical Review Division submitted a Notice to Requestor to submit additional documentation necessary to support the charges and to challenge the reasons the Respondent had denied reimbursement within 14 days of the Requestor's receipt of the Notice.

CPT codes 97545-WH-CA and 97546-WH-CA from 10-10-05 -10-21-05 and 10-31-05 – 11-23-05 were denied by the carrier as "W-2-Workers' compensation claim adjudicated as non-compensable. Carrier not liable for claim or service/treatment," "W-1-Workers Compensation State Fee Schedule Adjustment," and "18-Duplicate claim/service." These services were part of the Work Hardening Program which the IRO determined to be medically unnecessary. Per Rule 133.308 (p)(5) an IRO decision is deemed to be a Division decision and order. No reimbursement recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 134.1
Texas Labor Code 413.031

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 Division has determined that the Requestor is not entitled to reimbursement of the IRO fee and is not entitled to reimbursement for the services involved in this dispute.

Findings and Decision and Order by:

Medical Dispute Officer

10-13-06

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.

IRO America Inc.

An Independent Review Organization

7626 Parkview Circle

Austin, TX 78731

Phone: 512-346-5040

Fax: 512-692-2924

Amended September 15, 2006
September 13, 2006

TDI-DWC Medical Dispute Resolution
Fax: (512) 804-4868

Patient:

TDI-DWC #:

MDR Tracking #:

M5-06-1876-01

IRO #:

5251

IRO America Inc. (IRO America) has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI, Division of Workers' Compensation (DWC) has assigned this case to IRO America for independent review in accordance with DWC Rule 133.308 which allows for medical dispute resolution by an IRO.

IRO America has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor; the Reviewer is a credentialed Panel Member of IRO America's Medical Knowledge Panel who is a licensed Provider, board certified and specialized in Chiropractic Care. The reviewer is on the DWC Approved Doctor List (ADL).

The IRO America Panel Member/Reviewer is a health care professional who has signed a certification statement stating that no known conflicts of interest exist between the Reviewer 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 carriers health care providers who reviewed the case for decision before referral to IRO America for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

RECORDS REVIEWED

Notification of IRO Assignment, records from the Requestor, Respondent, and Treating Doctor(s), including but not limited to: explanation of benefits, notes from North Texas Pain Recovery Center, FCE dated 10/03/2005 and 12/01/2005, Behavioral Health Assessment by Michael Walker Ed. D, and notes from David Graybill DO.

CLINICAL HISTORY

A limited history is provided. This Patient injured her low back while lifting a box of phone books from her vehicle. She is employed by ____ as an administrative assistant/ customer service agent.

DISPUTED SERVICE(S)

Under dispute is the retrospective medical necessity of work hardening and work hardening each additional hour for the dates 10/24/05 through 10/28/05.

DETERMINATION/DECISION

The Reviewer agrees with the determination of the insurance company.

RATIONALE/BASIS FOR THE DECISION

The medical records shows that the Patient was diagnosed with an 847.2 - lumbar sprain/ strain. This is a self-limiting diagnosis that will resolve anywhere from 4 to 12 weeks depending on the mechanism of injury. There did not appear to be any diagnostic tests performed to investigate if there was any internal derangement within the lumbar joints, leaving the diagnosis to be a soft tissue injury of a lumbar sprain/ strain. The disputed service is performed well over two years post injury and one cannot reasonably expect any positive outcome from these services according to the *Texas Guidelines for Quality Assurance and Practice Parameters*. This Patient is also well over the statutory MMI of 104 weeks and also reached MMI early on as again this is a self limiting diagnosis code, therefore, the disputed services are not reasonable or medically necessary.

Screening Criteria

1. Specific: Texas Guidelines for Quality Assurance and Practice Parameters
2. General: In making his determination, the Reviewer had reviewed medically acceptable screening criteria relevant to the case, which may include but is not limited to any of the following: Evidence Based Medicine Guidelines (Helsinki, Finland); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Texas Chiropractic Association: Texas Guidelines to Quality Assurance (Austin Texas); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Mercy Center Guidelines of Quality

Assurance; any and all guidelines issued by DWC or other _____, standards contained in Medicare Coverage Database; ACOEM Guidelines; peer-reviewed literature and scientific studies that meet nationally recognized standards; standard references compendia; and findings; studies conducted under the auspices of federal government agencies and research institutes; the findings of any national board recognized by the National Institutes of Health; peer reviewed abstracts submitted for presentation at major medical associates meetings; any other recognized authorities and systems of evaluation that are relevant.

CERTIFICATION BY OFFICER

IRO America has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. IRO America has made no determinations regarding benefits available under the injured employee's policy. As an officer of IRO America Inc., I certify that there is no known conflict between the Reviewer, IRO America and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

IRO America is forwarding by facsimile, a copy of this finding to the DWC.

Sincerely,

IRO America Inc.



Dr. Roger Glenn Brown

President & Chief Resolutions Officer

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. The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

I hereby certify, in accordance with DWC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to DWC via facsimile, on this 13th day of September, 2006.

Name and Signature of IRO America Representative:

Sincerely,

IRO America Inc.



Dr. Roger Glenn Brown

President & Chief Resolutions Officer