

3-16-05	99211 (Global to 98940)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$0.00
3-22-05	97010 (Bundled code)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$0.00
3-14-05, 3-18-05, 3-22-05, 3-25-05, 3-29-05	97032 (\$20.53 x 5 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$102.65
3-29-05	97113-59 (1 unit only)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$41.70
4-21-05, 5-27-05	99080-73 (\$15.00 x 2 days)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$30.00
4-27-05, 6-3-05	97750-FC (\$38.65 x 20 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$773.00
3-16-05	99354-25	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$127.49
All dates of service not noted above	97545-WC, 99211, 99214, 97140-59, 97035, 97016, 97012, 97032, 98940, 97113-59, 97110, 93799	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
Total Due			\$1,984.73

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 Independent Review Organization to conduct a review of the medical necessity issues between the Requestor and Respondent.

All services were denied by the carrier as "414-Disallowed; this claim is non-compensable" and as "U-Unnecessary treatment, no peer review." In a position paper dated April 3, 2006 the Respondent states that the ankle sprain is the compensable injury. The Requestor billed with the diagnosis code of 845.0-sprain/strain, ankle. These services are compensable. Recommend reimbursement per Rules 133.308 and 134.202(b) and (c) (1).

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 3-21-06 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 code 99455-WP-V4 on 6-14-05 was denied by the carrier as "414-Disallowed; this claim is non-compensable" and as "U-Unnecessary treatment, no peer review." These services are compensable (see above). This is a DWC required report and not subject to an IRO review; it was denied inappropriately. The Respondent will be billed for this violation. Recommend reimbursement per Rule 134.202(e)(6) of \$557.01 (Level 4 Office Visit plus Range of Motion Lower Extremity + DRE Low Back test).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.1 and 134.202
Texas Labor Code 413.011 and 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 a refund of the paid IRO fee. The Division has determined that the Requestor is entitled to reimbursement for the services involved in this dispute in the amount of \$2,541.74. 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.

Findings and Decision and Order by:

Medical Dispute Officer

1-18-07

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 esta correspondencia, favor de llamar a 512-804-4812.

I N D E P E N D E N T R E V I E W I N C O R P O R A T E D

September 18, 2006

AMENDED November 27, 2006

FORMERLY M4-06-4594-01

Re: **MDR #: M5 06 1906 01**

DWC #:

IRO Cert. #: 5055

Injured Employee: ___

DOI: ___

SS#: ___

TRANSMITTED VIA FAX TO:

TDI, Division of Workers' Compensation

Attention: Medical Dispute Resolution

 Fax: (512) 804-4868

RESPONDENT: Downs Stanford

TREATING DOCTOR: Brian Weddle, 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 a chiropractor who 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,



Jeff Cunningham, DC
Office Manager

I N D E P E N D E N T R E V I E W I N C O R P O R A T E D

REVIEWER'S REPORT

M5 06 1906 01

MEDICAL INFORMATION REVIEWED:

DWC Assignment
Carrier records
Treating doctor records

BRIEF CLINICAL HISTORY:

This patient was injured on the job when she slid down a pole. She had complaints of right ankle, right knee and low back pain. The right knee was injured and the right ankle was sprained in the accident. As the patient had a past history of low back pain, the carrier has denied the low back compensability. RME by Dr. Patrick Donovan indicated negative testing of the knee and ankle and a pre-existing low back degeneration. Eventually, the carrier did accept the low back pain as part of the injury, but the carrier's representative denies that treatment for the injury was medically necessary.

DISPUTED SERVICES:

The carrier has denied the medical necessity of 72100—X-ray, 73560—X-ray; 99211, 99214—office visits; 97140-59—manual therapy technique; 97035—ultrasound; 97016—vasopneumatic device; 97012—mechanical traction; 97032—electrical stimulation; 98940—chiropractic manual treatment; 97010—hot/cold pack therapy; 97113—aquatic therapy; 99354-25—prolonged physician service; 99080-73—DWC Report; 97110—Therapeutic exercises; 97545—work hardening program; 97750—FCE, 93799—unlisted cardiovascular services, from March 14, 2005 through June 14, 2005.

DECISION:

I partially agree with the carrier in this case. Office visits, Passive treatment, to include manual therapy, ultrasound, vasopneumatic device, mechanical traction, electrical stimulation, thermal packs and aquatic therapy would be necessary from March 14, 2005 through March 28, 2005, with no more than 6 treatments during that timeframe. Appropriate dates of service are March 14, 16, 18, 22, 25 and 29 of 2005. The records I have reviewed indicate that only 1 unit of 97113 would be necessary on March 29, 2005. All other treatment rendered on those 6 dates of service would be considered reasonable.

The DWC report is a required report and should be reimbursed for all dates the reports were issued. The FCE is also a reasonable assessment of the patient's condition and should be considered necessary. All other physical medicine was not documented as reasonable or necessary.

There is no medical necessity for work hardening in this case.

RATIONALE OR BASIS FOR DECISION:

This case clearly involves a patient who was injured. The carrier's position that the low back was injured but did not require treatment is erroneous. The treating doctor's protocol was one of overutilization of the passive modalities and no more than 6 of those office visits over a period of 2 weeks would be reasonable. Active care would be reasonable on this patient for 12 visits, considering the severity of the sprains to the knee, ankle and low back.

SCREENING CRITERIA/STUDIES

TCA Guidelines, Guidelines of the Mercy Conference.