



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

Requestors Name and Address: Rehab 2112 P. O. Box 671342 Dallas, TX 75267-1342	MDR Tracking No.: M5-06-1977-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Insurance Company, Box 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary (Table of Disputed Services) states, "Work Hardening is medically necessary."

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, "Position statement submitted by Texas Mutual does not address the disputed issues."

Principle Documentation:

1. DWC-60/Table of Disputed Service

PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

<u>Date(s) of Service</u>	<u>CPT Code(s) or Description</u>	<u>Medically Necessary?</u>	<u>Additional Amount Due (if any)</u>
1-27-06 – 2-14-06	97545-WH-CA (\$128.00 X 11 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,408.00
1-27-06 – 2-14-06	97546-WH-CA (\$64.00 X 52 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$3,328.00
	Grand total		\$4,736.00

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 prevail on the disputed medical necessity issues. Per Rule 134.202(e)(5)(c) the amount due the Requestor for the items denied for medical necessity is \$4,736.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.1, 134.202
Texas Labor Code Sec. § 413.011(a-d), 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 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 \$4,736.00. 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.

Findings and Decision and Order by:

Medical Dispute Officer

10-25-06

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

October 18, 2006

Re: MDR #: M5 06 1977 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: Texas Mutual

REQUESTOR: Rehab 2112

TREATING DOCTOR: Von Evans, MD

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,

The initials 'JC' are rendered in a large, bold, serif font. The 'J' is lowercase and the 'C' is uppercase. The 'J' has a small dot above it, and the 'C' is a simple, open-bottom curve.

Jeff Cunningham, DC
Office Manager

**REVIEWER'S REPORT
CASE NUMBER**

MEDICAL INFORMATION REVIEWED:

1. DWC Assignment
2. Carrier records
3. Requestor records

BRIEF CLINICAL HISTORY:

Mr. ___ was injured on the job and suffered both a left knee medial meniscus tear and a right shoulder labral tear. He underwent surgery on September 14, 2005 for these injuries and began rehabilitation shortly after then. He was unable to reach his required work category of heavy with active rehab and was placed in a work hardening program. The program did increase his strength from 15 to 35 pounds of maximum lifting.

DISPUTED SERVICES:

Work hardening program from January 27, 2006 through February 14, 2006

DECISION:

I DISAGREE WITH THE INSURANCE CARRIER'S PRIOR FINDING IN THIS CASE.

RATIONALE OR BASIS FOR DECISION:

Clearly this patient had serious injuries that required surgical intervention. In addition, there were 2 areas of surgical intervention. Records do indicate that the patient has developed a chronic pain syndrome, but still gave excellent effort in the work hardening program. There were no alternative programs for this patient at the point of entry into the work hardening program and the patient was appropriately referred for this program.

SCREENING CRITERIA/STUDIES

TCA Guidelines to Quality Assurance, Mercy Center Guidelines